

**State:** District of Columbia **Filing Company:** Aetna Health Inc. PA AZ DC DE IN KY MA MD NV  
NC OK TN VA WV  
**TOI/Sub-TOI:** HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only  
- HMO  
**Product Name:** DC AHI SG HMO 2020  
**Project Name/Number:** 2020 Exchange - Aetna/HMO

## Filing at a Glance

Company: Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV  
Product Name: DC AHI SG HMO 2020  
State: District of Columbia  
TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)  
Sub-TOI: HOrg02G.004F Small Group Only - HMO  
Filing Type: Rate  
Date Submitted: 05/24/2019  
SERFF Tr Num: AETN-131944461  
SERFF Status: Assigned  
State Tr Num:  
State Status:  
Co Tr Num: DCAHISG2020  
Implementation: 01/01/2020  
Date Requested:  
Author(s): Regis Murayi, Amy Ovuka, Joanna Kluza, Kyle Richardson, Elizabeth Mangan, Arthur Goodell  
Reviewer(s): Damon Siler (primary), Efren Tanhehco, John Morgan, Dave Dillon  
Disposition Date:  
Disposition Status:  
Implementation Date:  
  
State Filing Description:

**State:** District of Columbia **Filing Company:** Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV

**TOI/Sub-TOI:** HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

**Product Name:** DC AHI SG HMO 2020

**Project Name/Number:** 2020 Exchange - Aetna/HMO

## General Information

Project Name: 2020 Exchange - Aetna  
Project Number: HMO  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Group Market Type: Employer  
Filing Status Changed: 05/28/2019  
State Status Changed:  
Created By: Elizabeth Mangan  
Corresponding Filing Tracking Number:

Status of Filing in Domicile:  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Group  
Group Market Size: Small  
Overall Rate Impact: 16.1%

Deemer Date:  
Submitted By: Elizabeth Mangan

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions:

Includes forms for products to be offered to Small Groups on the DC Health Benefits Exchange.

Filing Description:

Aetna Health, Inc. 1Q20 Small Group HMO rate filing for DC.

The corresponding forms filing was submitted separately. The SERFF ID Number is AETN-131865435.

## Company and Contact

### Filing Contact Information

Regis Murayi, Actuarial Consultant  
151 Farmington Ave  
Hartford, CT 06156

MurayiR@aetna.com  
860-273-8566 [Phone]

### Filing Company Information

Aetna Health Inc. PA AZ DC DE  
IN KY MA MD NV NC OK TN VA  
WV  
1425 Union Meeting Road  
Blue Bell, PA 19422  
(999) 999-9999 ext. [Phone]

CoCode: 95109  
Group Code: 1  
Group Name:  
FEIN Number: 23-2169745

State of Domicile:  
Pennsylvania  
Company Type:  
State ID Number:

## Filing Fees

Fee Required? No  
Retaliatory? No  
Fee Explanation:

<b>SERFF Tracking #:</b>	AETN-131944461	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	DCAHISG2020
<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV		
<b>TOI/Sub-TOI:</b>	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO				
<b>Product Name:</b>	DC AHI SG HMO 2020				
<b>Project Name/Number:</b>	2020 Exchange - Aetna/HMO				

## Correspondence Summary

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Rate	DC AHI SG HMO 2020	Elizabeth Mangan	05/29/2019	05/29/2019
Rate	DC AHI SG HMO 2020	Elizabeth Mangan	05/28/2019	05/28/2019
Supporting Document	Supporting Documentation	Elizabeth Mangan	05/28/2019	05/28/2019

<b>SERFF Tracking #:</b>	AETN-131944461	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	DCAHISG2020
<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV		
<b>TOI/Sub-TOI:</b>	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO				
<b>Product Name:</b>	DC AHI SG HMO 2020				
<b>Project Name/Number:</b>	2020 Exchange - Aetna/HMO				

## Amendment Letter

Submitted Date: 05/29/2019

Comments:

Rate PDFs on Rate/Rule Schedule tab added

Changed Items:

*No Form Schedule Items Changed.*

State: District of Columbia Filing Company: Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV

TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name: DC AHI SG HMO 2020

Project Name/Number: 2020 Exchange - Aetna/HMO

Rate/Rule Schedule Item Changes						
Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	DC AHI SG HMO 2020	HI SG-SOB-HMO-14042181 04-HIX, HI SG-SOB-HMO-14042176 04-HIX, HI SG-SOB-HMO-14042177 04-HIX, HI SG-SOB-HMO-14042182 04-HIX, HI SG-SOB-HMO-14042179 04-HIX, HI SG-SOB-HMO-14042188 04-HIX, HI SG-SOB-HMO-14042180 04-HIX, HI SG-SOB-HMO-14042178 04-HIX	Revised	Previous State Filing Number: AETN-131520634 Percent Rate Change Request: 16.1	DC_SG_73987_Rates_ON_1Q2020_v1a.xls m, DC_SG_73987_Rates_ON_1Q2020_v1a_IVL.xlsm, DC_SG_73987_Rates_ON_1Q2020_v1.pdf, DC_SG_73987_Rates_ON_2Q2020_v1.pdf, DC_SG_73987_Rates_ON_3Q2020_v1.pdf, DC_SG_73987_Rates_ON_4Q2020_v1.pdf, DC_SG_73987_Rates_ON_1Q2020_v1_IVL.pdf, DC_SG_73987_Rates_ON_2Q2020_v1_IVL.pdf, DC_SG_73987_Rates_ON_3Q2020_v1_IVL.pdf, DC_SG_73987_Rates_ON_4Q2020_v1_IVL.pdf,	05/29/2019 By:
Previous Version						
1	DC AHI SG HMO 2020	HI SG-SOB-HMO-14042181 04-HIX, HI SG-SOB-HMO-14042176 04-HIX, HI SG-SOB-HMO-14042177 04-HIX, HI SG-SOB-HMO-14042182 04-HIX, HI SG-SOB-HMO-14042179 04-HIX, HI SG-SOB-HMO-14042188 04-HIX, HI	Revised	Previous State Filing Number: AETN-131520634 Percent Rate Change Request: 16.1	DC_SG_73987_Rates_ON_1Q2020_v1a.xls m, DC_SG_73987_Rates_ON_1Q2020_v1a_IVL.xlsm,	05/28/2019 By:

<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV
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**TOI/Sub-TOI:** HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

**Product Name:** DC AHI SG HMO 2020

**Project Name/Number:** 2020 Exchange - Aetna/HMO

Rate/Rule Schedule Item Changes						
		SG-SOB-HMO-14042180 04-HIX, HI SG-SOB-HMO-14042178 04-HIX				
<i>Previous Version</i>						
1	DC AHI SG HMO 2020	HI SG-SOB-HMO-14042181 04-HIX, HI SG-SOB-HMO-14042176 04-HIX, HI SG-SOB-HMO-14042177 04-HIX, HI SG-SOB-HMO-14042182 04-HIX, HI SG-SOB-HMO-14042179 04-HIX, HI SG-SOB-HMO-14042188 04-HIX, HI SG-SOB-HMO-14042180 04-HIX, HI SG-SOB-HMO-14042178 04-HIX	Revised	Previous State Filing Number: AETN-131520634 Percent Rate Change Request: 16.1	DC_SG_73987_Rates_ON_1Q2020_v1.xlsm, DC_SG_73987_Rates_ON_1Q2020_v1_IVL.xlsm,	05/24/2019 By: Elizabeth Mangan

No Supporting Documents Changed.

<b>SERFF Tracking #:</b>	AETN-131944461	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	DCAHISG2020
<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV		
<b>TOI/Sub-TOI:</b>	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO				
<b>Product Name:</b>	DC AHI SG HMO 2020				
<b>Project Name/Number:</b>	2020 Exchange - Aetna/HMO				

## Amendment Letter

Submitted Date: 05/28/2019

Comments:

Rate files on Rate/Rule Schedule Updated

Changed Items:

*No Form Schedule Items Changed.*

State: District of Columbia Filing Company: Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV

TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name: DC AHI SG HMO 2020

Project Name/Number: 2020 Exchange - Aetna/HMO

Rate/Rule Schedule Item Changes						
Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	DC AHI SG HMO 2020	HI SG-SOB-HMO-14042181 04-HIX, HI SG-SOB-HMO-14042176 04-HIX, HI SG-SOB-HMO-14042177 04-HIX, HI SG-SOB-HMO-14042182 04-HIX, HI SG-SOB-HMO-14042179 04-HIX, HI SG-SOB-HMO-14042188 04-HIX, HI SG-SOB-HMO-14042180 04-HIX, HI SG-SOB-HMO-14042178 04-HIX	Revised	Previous State Filing Number: AETN-131520634 Percent Rate Change Request: 16.1	DC_SG_73987_Rates_ON_1Q2020_v1a.xls m, DC_SG_73987_Rates_ON_1Q2020_v1a_IVL.xlsm,	05/28/2019 By:
Previous Version						
1	DC AHI SG HMO 2020	HI SG-SOB-HMO-14042181 04-HIX, HI SG-SOB-HMO-14042176 04-HIX, HI SG-SOB-HMO-14042177 04-HIX, HI SG-SOB-HMO-14042182 04-HIX, HI SG-SOB-HMO-14042179 04-HIX, HI SG-SOB-HMO-14042188 04-HIX, HI SG-SOB-HMO-14042180 04-HIX, HI SG-SOB-HMO-14042178 04-HIX	Revised	Previous State Filing Number: AETN-131520634 Percent Rate Change Request: 16.1	DC_SG_73987_Rates_ON_1Q2020_v1.xlsm, DC_SG_73987_Rates_ON_1Q2020_v1_IVL.xlsm,	05/24/2019 By: Elizabeth Mangan

No Supporting Documents Changed.



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<b>TOI/Sub-TOI:</b>	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO		
<b>Product Name:</b>	DC AHI SG HMO 2020		
<b>Project Name/Number:</b>	2020 Exchange - Aetna/HMO		

## Amendment Letter

Submitted Date: 05/28/2019

Comments:

Updated to include Components of Increase file

Changed Items:

*No Form Schedule Items Changed.*

*No Rate Schedule Items Changed.*

Supporting Document Schedule Item Changes	
<b>Satisfied - Item:</b>	Supporting Documentation
<b>Comments:</b>	
<b>Attachment(s):</b>	ACT Memo Exhibits from FACT_DC - AHI - 1Q2020.pdf Exhibit 12 - AHI Key Factors.pdf Exhibit A-1 - AHI Rate Change by plan.pdf Exhibit A-2_DC_SG_73987_AV_Screenshots_2020.pdf 2020Aetna AVCCert Template_DC_AHI.pdf DISB Filing Checklist - AHI 2020.pdf Exhibit 12 - AHI Key Factors IVL.pdf ACT Memo Exhibits from FACT_DC - AHI - 1Q2020 IVL.pdf Exhibit A-1 - AHI Rate Change by plan IVL.pdf Exhibit A-2_DC_SG_73987_AV_Screenshots_2020.pdf DISB Filing Checklist - AHI 2020 IVL.pdf DC_SG_73987_ComponentsOfIncreaseAHI.pdf
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	<i>Supporting Documentation</i>
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>ACT Memo Exhibits from FACT_DC - AHI - 1Q2020.pdf</i> <i>Exhibit 12 - AHI Key Factors.pdf</i> <i>Exhibit A-1 - AHI Rate Change by plan.pdf</i> <i>Exhibit A-2_DC_SG_73987_AV_Screenshots_2020.pdf</i> <i>2020Aetna AVCCert Template_DC_AHI.pdf</i> <i>DISB Filing Checklist - AHI 2020.pdf</i> <i>ACT Memo Exhibits from FACT_DC - AHI - 1Q2020 IVL.pdf</i> <i>Exhibit A-1 - AHI Rate Change by plan IVL.pdf</i> <i>Exhibit A-2_DC_SG_73987_AV_Screenshots_2020.pdf</i> <i>Exhibit 12 - AHI Key Factors IVL.pdf</i> <i>DISB Filing Checklist - AHI 2020 IVL.pdf</i>

<b>SERFF Tracking #:</b>	AETN-131944461	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	DCAHISG2020
<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV		
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<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV		
<b>TOI/Sub-TOI:</b>	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO				
<b>Product Name:</b>	DC AHI SG HMO 2020				
<b>Project Name/Number:</b>	2020 Exchange - Aetna/HMO				

## Rate Information

Rate data applies to filing.

<b>Filing Method:</b>	Review & Approval
<b>Rate Change Type:</b>	Increase
<b>Overall Percentage of Last Rate Revision:</b>	3.420%
<b>Effective Date of Last Rate Revision:</b>	01/01/2019
<b>Filing Method of Last Filing:</b>	Review & Approval
<b>SERFF Tracking Number of Last Filing:</b>	AETN-131520634

## Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV	Increase	16.100%	16.100%	\$-382,727	4	\$28,053	30.800%	4.600%

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**Product Name:** DC AHI SG HMO 2020

**Project Name/Number:** 2020 Exchange - Aetna/HMO

## Rate Review Detail

### COMPANY:

Company Name: Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV

HHS Issuer Id: 73987

### PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
DC AHI SG HMO	73987DC004	73987-1488629421191205918	850

Trend Factors:

### FORMS:

New Policy Forms: HI SG-SOB-HMO-14042181 04-HIX, HI SG-SOB-HMO-14042176 04-HIX, HI SG-SOB-HMO-14042177 04-HIX, HI SG-SOB-HMO-14042182 04-HIX, HI SG-SOB-HMO-14042179 04-HIX, HI SG-SOB-HMO-14042188 04-HIX, HI SG-SOB-HMO-14042180 04-HIX, HI SG-SOB-HMO-14042178 04-HIX

Affected Forms:

Other Affected Forms:

### REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly

Member Months: 2,724

Benefit Change: None

Percent Change Requested: Min: 4.6 Max: 30.8 Avg: 16.1

### PRIOR RATE:

Total Earned Premium: 410,780.00

Total Incurred Claims: 339,227.00

Annual \$: Min: 398.34 Max: 483.16 Avg: 483.27

### REQUESTED RATE:

Projected Earned Premium: 28,053.00

Projected Incurred Claims: 16,351.00

Annual \$: Min: 416.66 Max: 631.97 Avg: 561.08

SERFF Tracking #:

AETN-131944461

State Tracking #:

Company Tracking #:

DCAHISG2020

State:

District of Columbia

Filing Company:

Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA  
WV

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name:

DC AHI SG HMO 2020

Project Name/Number:

2020 Exchange - Aetna/HMO

## Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		DC AHI SG HMO 2020	HI SG-SOB-HMO-14042181 04-HIX, HI SG-SOB-HMO-14042176 04-HIX, HI SG-SOB-HMO-14042177 04-HIX, HI SG-SOB-HMO-14042182 04-HIX, HI SG-SOB-HMO-14042179 04-HIX, HI SG-SOB-HMO-14042188 04-HIX, HI SG-SOB-HMO-14042180 04-HIX, HI SG-SOB-HMO-14042178 04-HIX	Revised	Previous State Filing Number: AETN-131520634 Percent Rate Change Request: 16.1	DC_SG_73987_Rates_ON_1Q2020_v1a.xls m, DC_SG_73987_Rates_ON_1Q2020_v1a_IVL. .xlsm, DC_SG_73987_Rates_ON_1Q2020_v1.pdf, DC_SG_73987_Rates_ON_2Q2020_v1.pdf, DC_SG_73987_Rates_ON_3Q2020_v1.pdf, DC_SG_73987_Rates_ON_4Q2020_v1.pdf, DC_SG_73987_Rates_ON_1Q2020_v1_IVL. pdf, DC_SG_73987_Rates_ON_2Q2020_v1_IVL. pdf, DC_SG_73987_Rates_ON_3Q2020_v1_IVL. pdf, DC_SG_73987_Rates_ON_4Q2020_v1_IVL. pdf,

<b>SERFF Tracking #:</b>	AETN-131944461	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	DCAHISG2020
<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV		
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***Attachment DC\_SG\_73987\_Rates\_ON\_1Q2020\_v1a.xlsm is not a PDF document and cannot be reproduced here.***

***Attachment DC\_SG\_73987\_Rates\_ON\_1Q2020\_v1a\_IVL.xlsm is not a PDF document and cannot be reproduced here.***

Table 1: Summary of Data									
Table 2: Detailed Data									
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<b>SERFF Tracking #:</b>	AETN-131944461	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	DCAHISG2020
<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV		
<b>TOI/Sub-TOI:</b>	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO				
<b>Product Name:</b>	DC AHI SG HMO 2020				
<b>Project Name/Number:</b>	2020 Exchange - Aetna/HMO				

## Supporting Document Schedules

<b>Bypassed - Item:</b>	Actuarial Justification
<b>Bypass Reason:</b>	This is not a new form filing.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Actuarial Memorandum
<b>Comments:</b>	
<b>Attachment(s):</b>	DC_SG_State_Actuarial_Memo_1Q2020_AHI.pdf DC_SG_State_Actuarial_Memo_1Q2020_AHI_IVL.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Actuarial Memorandum and Certifications
<b>Comments:</b>	
<b>Attachment(s):</b>	DC_SG_73987_URRT_Part_III_Memo_and_Cert_AHI_2020.pdf DC_SG_73987_URRT_Part_III_Memo_and_Cert_AHI_2020_redacted.pdf DC_SG_73987_URRT_Part_III_Memo_and_Cert_AHI_2020_IVL.pdf DC_SG_73987_URRT_Part_III_Memo_and_Cert_AHI_2020_IVL_Redacted.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Bypassed - Item:</b>	Certificate of Authority to File
<b>Bypass Reason:</b>	The filing is being made by Aetna.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Consumer Disclosure Form
<b>Comments:</b>	
<b>Attachment(s):</b>	DC_SG_73987_Part_II_Consumer_Disclosure_AHI_1Q2020.pdf DC_SG_73987_Part_II_Consumer_Disclosure_AHI_1Q2020_IVL.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Cover Letter

<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV
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<b>TOI/Sub-TOI:</b>	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO
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<b>Product Name:</b>	DC AHI SG HMO 2020
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<b>Project Name/Number:</b>	2020 Exchange - Aetna/HMO
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<b>Comments:</b>	
<b>Attachment(s):</b>	DC SG SHOP Cover Letter - AHI 1Q20.pdf DC SG SHOP Cover Letter - AHI 1Q20_IVL.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	DISB Actuarial Memorandum Dataset
<b>Comments:</b>	
<b>Attachment(s):</b>	DISB Actuarial Memo Dataset_AHI_2020_IVL.xlsx DISB Actuarial Memo Dataset_AHI_2020.xlsx
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)
<b>Bypass Reason:</b>	This is not a P & C Filing.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	District of Columbia and Countrywide Loss Ratio Analysis (P&C)
<b>Bypass Reason:</b>	This is not a P & C Filing.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Unified Rate Review Template
<b>Comments:</b>	
<b>Attachment(s):</b>	DC_SG_73987_URRT_ON_1Q2020_v1.pdf DC_SG_73987_URRT_ON_1Q2020_v1.xlsm DC_SG_73987_URRT_ON_1Q2020_v1_IVL.pdf DC_SG_73987_URRT_ON_1Q2020_v1_IVL.xlsm
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	District of Columbia Plain Language Summary
<b>Comments:</b>	
<b>Attachment(s):</b>	DISB Plain Language Summary - AHI - 1Q2020.pdf DISB Plain Language Summary - AHI - 1Q2020 IVL.pdf
<b>Item Status:</b>	



<b>SERFF Tracking #:</b>	AETN-131944461	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	DCAHISG2020
<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV		
<b>TOI/Sub-TOI:</b>	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO				
<b>Product Name:</b>	DC AHI SG HMO 2020				
<b>Project Name/Number:</b>	2020 Exchange - Aetna/HMO				
<b>Status Date:</b>					
<b>Satisfied - Item:</b>	Supporting Documentation				
<b>Comments:</b>					
<b>Attachment(s):</b>	ACT Memo Exhibits from FACT_DC - AHI - 1Q2020.pdf Exhibit 12 - AHI Key Factors.pdf Exhibit A-1 - AHI Rate Change by plan.pdf Exhibit A-2_DC_SG_73987_AV_Screenshots_2020.pdf 2020Aetna AVCCert Template_DC_AHI.pdf DISB Filing Checklist - AHI 2020.pdf Exhibit 12 - AHI Key Factors IVL.pdf ACT Memo Exhibits from FACT_DC - AHI - 1Q2020 IVL.pdf Exhibit A-1 - AHI Rate Change by plan IVL.pdf Exhibit A-2_DC_SG_73987_AV_Screenshots_2020.pdf DISB Filing Checklist - AHI 2020 IVL.pdf DC_SG_73987_ComponentsOfIncreaseAHI.pdf				
<b>Item Status:</b>					
<b>Status Date:</b>					

<b>SERFF Tracking #:</b>	AETN-131944461	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	DCAHISG2020
<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV		
<b>TOI/Sub-TOI:</b>	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO				
<b>Product Name:</b>	DC AHI SG HMO 2020				
<b>Project Name/Number:</b>	2020 Exchange - Aetna/HMO				

***Attachment DISB Actuarial Memo Dataset\_AHI\_2020\_IVL.xlsx is not a PDF document and cannot be reproduced here.***

***Attachment DISB Actuarial Memo Dataset\_AHI\_2020.xlsx is not a PDF document and cannot be reproduced here.***

***Attachment DC\_SG\_73987\_URRT\_ON\_1Q2020\_v1.xlsm is not a PDF document and cannot be reproduced here.***

***Attachment DC\_SG\_73987\_URRT\_ON\_1Q2020\_v1\_IVL.xlsm is not a PDF document and cannot be reproduced here.***

**Aetna Health Inc. – District of Columbia**  
**1Q20 Filing - Small Group Business**  
**HIOS product ID: 73987DC004**  
**Actuarial Memorandum**

**Statement of Purpose for Filing**

This actuarial memorandum supports Aetna Health Inc. commercial base rates for District of Columbia small groups effective beginning January 1, 2020. The purpose of this memorandum is to comply with the District of Columbia, Department of Insurance, Securities and Banking, Health Insurance Rate Filing Procedures and to provide adequate supporting information for our proposed rates pursuant to the DC Official Code, Title 31, Subtitle IV, Chapter 34.

The requested rates have been developed incorporating consideration of the market changes and rating requirements taking effect in the Small Group market pursuant to the Patient Protection and Affordable Care Act of 2010 and subsequent regulation. They are compliant with all rating limitations under federal and state regulation. The plan designs contained in this submission are to be sold on the Exchange.

The descriptions and analyses presented in this rate filing reflect our current understanding of regulations and guidance. As further guidance is received, we reserve the right to submit revisions or withdraw this rate filing.

**Summary of Changes from prior filing and rate manual**

We are proposing to revise the quarterly premium rates for effective dates from January 1, 2020, through December 31, 2020. The quarterly rate increases are reflected in Exhibit 7. Generally, rate changes do not vary by plan design, with the exception of the impact associated with plan-specific benefit modifications necessary to comply with Actuarial Value requirements.

Rates for the plans in this submission are being revised to reflect 1) the impact of updated experience data and medical claim trend and 2) changes in cost-sharing levels to ensure that plans comply with Actuarial Value requirements.

There are no other proposed changes for this submission.

**Form Numbers**

An exhibit showing the Form Numbers is shown on under the "Certificate of Form Names and Numbers" Exhibit of this Actuarial Memorandum.

**Status of Forms**

The forms for this submission are "open to new sales" and "non-grandfathered".

**Description of Benefits/Metal Levels and Actuarial Values**

This filing covers HMO group medical benefit coverage. The range of coverage includes inpatient, outpatient, primary care, specialist services, pharmacy, DME, and vision. Information on the cost-sharing parameters of the covered benefit plans, including deductibles and copays, can be found in the Schedule of Benefits in the Form filing (AETN-131865435). All benefits are compliant with state mandates and the requirements of the Patient Protection and Affordable Care Act of 2010, including preventive care benefits, deductible limits, and Actuarial Value requirements.

Exhibit A shows the metal level and actuarial value for each plan design using the AV calculator developed and made available by HHS.

### Average Rate Increase Requested

The following tables provide the requested weighted average increases. The first table shows the incremental increase and the second table shows the year over year increase.

	1Q20/4Q19	2Q20/1Q20	3Q20/2Q20	4Q20/3Q20
<b>Incremental Rate Increase</b>	5.17%	2.95%	2.95%	2.95%

	1Q20/1Q19	2Q20/2Q19	3Q20/3Q19	4Q20/4Q19	Average
<b>Requested Rate Increase</b>	16.69%	16.04%	15.40%	14.74%	16.13%

### Maximum Rate Increase Requested

The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rate factors is 31.41%. This rate increase applies to members renewing in 1Q20 for the DC Bronze HNOOnly 6000 80% \$15/50 E plan (HIOS ID 73987DC0040056).

### Minimum Rate Increase Requested

The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rate factors is 3.37%. This rate increase applies to members renewing in 4Q20 for the DC Gold HNOOnly 1500 90% E plan (HIOS ID 73987DC0040058).

### Absolute Maximum Premium Increase

The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes like aging, is 43.64%. This rate increase applies to members renewing in 1Q20 for the DC Bronze HNOOnly 6000 80% \$15/50 E (HIOS ID 73987DC0040056) that age up from 20 to 21.

### Average Renewal Rate Increase for a Year

The average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing is 16.13%

### Rate Change History

The rate change history for the forms referenced in the filing is shown below.

Rate Effective Date	Annual Total Change
4Q18	8.7%
1Q19	1.7%
2Q19	2.6%
3Q19	3.5%
4Q19	4.4%

## Exposure

The current exposure as of December 2018 is 39 policies, 124 certificates, and 177 covered lives.

## Member Months

The numbers of members in force during each month of the base experience used in the rate development and for the preceding 12 month period for the forms referenced in this filing are shown in the Loss Ratio History Exhibit of the Actuarial Memorandum.

## Past Experience

The monthly earned premium and incurred claims for the base experience period used in the rate development and for the preceding 12 month period for the forms referenced in this filing are shown in the Loss Ratio History Exhibit of the Actuarial Memorandum.

## Index Rate

The index rate = \$550.64.

## Rate Development

### Determination of Claim Portion of Market Index Rate

In setting the projected claim level in the market in 2020, we based our projections upon the 2018 experience of our current ACA small group block of business for Innovation Health Plan, Inc. and Innovation Health Insurance Company, in the 2-50 market. The experience data utilized in the rate development reflects incurred claims from January 1, 2018 to December 31, 2018 and paid through February 2019. This manual experience is the HMO Small Group Experience for Innovation Health Plan, Inc. and PPO Small Group Experience for Innovation Health Insurance Company in Northern Virginia.

The manual experience used to develop the rates is shown below:

DOS	Membership	Claims	Premium *	Loss Ratio
01/01/2018	13,992	3,931,541	6,115,969	64.28%
02/01/2018	13,476	3,851,824	5,924,396	65.02%
03/01/2018	12,992	3,499,803	5,745,034	60.92%
04/01/2018	12,183	3,373,125	5,419,071	62.25%
05/01/2018	11,525	3,603,869	5,151,369	69.96%
06/01/2018	10,635	3,664,768	4,799,901	76.35%
07/01/2018	9,984	3,093,389	4,549,470	67.99%
08/01/2018	9,494	3,603,007	4,341,772	82.98%
09/01/2018	8,435	2,546,045	3,926,947	64.84%
10/01/2018	7,437	2,879,459	3,476,116	82.84%
11/01/2018	6,954	2,342,198	3,254,322	71.97%
12/01/2018	3,867	960,037	1,951,448	49.20%
<b>Total</b>	<b>120,974</b>	<b>37,349,065</b>	<b>54,655,817</b>	<b>68.34%</b>

\*Note: Premiums shown are not risk adjusted. The current estimate of the 2018 risk adjusted loss ratio is 71.1%.

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects one month of paid claim run-off. The IBNP reserves account for approximately 0.31% of the experience period incurred claims.

For the projection, the following was taken into consideration:

A. Changes in the Morbidity of the Population Insured:

The experience period data includes experience for policies issued to small employers in 2017 and 2018. We considered the expected relationships between the morbidity of the experience policies and the likely population that will be covered by Small Group Single Risk Pool policies in 2020.

B. Changes in Benefits:

The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for Single Risk Pool products that have essentially identical benefits.

The change in projected utilization due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.

C. Changes in Demographics:

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibits 2 and 3 contain detail on the calculations of the impact of demographic mix shifts.

D. Other Adjustments:

The 'Other' adjustment includes the projected impact of changes in network composition and provider contracts.

Determination of Retention Portion of Market Index Rate

The retention portion of the projected premium is illustrated in Exhibit 5.

The prospective general and administrative expenses are based on historical corporate small group market expense levels, current-year projections, and projected changes in expenses, inflation, and membership for 2020. The commission expense factor covers anticipated sales and marketing expenses. Those may include, without limitation, purchase of television, internet and other advertising; payments of commissions and other incentive compensation to Company's internal sales force; and payment of commissions to external brokers. The exact amounts and distribution among the categories of sales and marketing expenses will depend on a variety of factors including competitive conditions, business strategy, consumer behaviors, and legal and regulatory requirements. The consumer behaviors would capture whether they use a particular distribution channel, commissioned or not, as well as their experience.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2020, as well as Federal income tax. The risk adjustment user fee is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

The profit and risk load is consistent with the target used in our initial pricing of 2019.

### **Requested Rates**

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three dependents under age 21, only the three oldest dependents will be considered in determining the family's premium. Additional dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:

Calibrated Plan Adjusted Index Rate \* Age Factor \* Area Factor \* Trend Factor

The resulting rate is rounded to the nearest cent, and rates are then summed for all billable family members.

An example of a contract's premium determined by the member build-up calculation is shown in Exhibit 9.

### **Credibility Assumption**

Experience data for the District of Columbia is assigned 23% credibility.

### **Trend Assumption**

Anticipated annual trend from the experience period to the rating period for the product line is shown in the following table. The table shows the trend assumptions by major types of service as defined by HHS, separately by unit cost, utilization, and in total.

<b>Type of Service</b>	<b>Unit Cost</b>	<b>Utilization</b>	<b>Total</b>
Inpatient Hospital	5.9%	2.8%	8.9%
Outpatient Hospital	4.1%	6.8%	11.2%
Professional	1.5%	6.3%	7.9%
Other Medical	4.1%	6.8%	11.2%
Capitation	0.0%	N/A	0.0%
Prescription Drug	11.7%	3.3%	15.4%
<b>Total</b>	<b>5.8%</b>	<b>4.8%</b>	<b>10.8%</b>

#### **a. Medical Trend**

Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

#### **b. Pharmacy Trend**

Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend.

## Cost-sharing changes & Benefit Changes

Aetna's rate review models project incurred claims and earned premiums assuming a static benefit plan mix for the book of business for the experience period. Since Aetna prices the book of business utilizing a target loss ratio approach, adjustments made to the incurred claims and earned premiums to account for the anticipated changes to the plan mix would offset resulting in the same projected loss ratio. The Plan Relativity Factors adjust future premium levels to align with the expected claims for changes in plan mix for future dates of service.

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The Plan Relativities represent the expected value of the difference in benefits and networks between the market index rate and each additional proposed benefit plan discussed in this filing. The relativities were developed using a proprietary pricing model which relies on State- and product-specific benefit service category weights and rating factors for various levels of plan/member cost-sharing options for deductibles, coinsurance, out-of-pocket maximums and copays.

The product-specific service category weights were developed based on the experience of Aetna's Small Group block of business. The cost-sharing-specific rating factors were developed using experience associated with our Large Group block of business, which excludes the effects of selection. These Large Group based cost-sharing specific rating factors account for differences in a standard population's spending patterns due to differences in the richness and/or structure of benefits, or induced demand, without reflection of differences in health status.

Final plan relativities reflect the value of the EHB and state mandated benefits (including pediatric dental), incorporating the impact of out-of-network benefits and additional benefits. The methodology also considers the value of any differences in network by plan, including but not limited to network discounts and steerage.

The Plan Relativities for each plan are shown in the AV Pricing Value Column of Exhibit E-2.

### Rating Factors

#### Effective Date Factors

Exhibit 7 illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. Trend factors are developed from annual forward trend, and leveraging. A trend factor of 1.00 corresponds to a policy period that begins January 1, 2020.

#### Member Age Factor

The age factors are based on the DC specific age scale. The factors are shown in Exhibit 11.

#### Tobacco Factors

No load is proposed for tobacco users.

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Exhibit 3 summarizes the rating area definitions and factors, and displays the projected membership by area to develop the projected average area factor. The geographic calibration factor is the reciprocal of the projected average area factor.

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may also encourage and incent members in connection with participation in a wellness or health improvement program. Incentives include but are not limited to:

- Modification to **copayment, deductible or coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health.

### **Distribution of Rate Increases**

The distribution of rate increases (annual) is shown in Exhibit A-1. The increases are shown by Plan.

### **Claim Reserve Needs**

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

The experience data reflects incurred claims from January 1, 2018 through December 31, 2018 and paid through February 28, 2019. The paid claims for the DC Base experience period are \$1,661,807. The estimated incurred claims are \$1,666,898.

### **Administrative Costs of Programs that Improve Health Care Quality**

The administrative costs included with claims in the numerator of the MLR calculation are shown in Exhibit 6 (MLR Projection).

### **Taxes and Licensing or Regulatory Fees**

The taxes, licenses and fees removed from premium in the denominator of the MLR calculation are shown in Exhibit 6 (MLR Projection).

### **Medical Loss Ratio (MLR)**

The projected Medical Loss Ratio (MLR) as defined by HHS is 85.2% and meets the minimum MLR requirements of Insurance Art. § 15-605(c). The details of the MLR calculation are shown in Exhibit 6 (MLR Projection).

### **Risk Adjustment**

#### Risk Adjustment – Experience Period

Risk Adjustment transfer based on 2018 Wakely Accruals. The transfer is allocated to the member-level based by applying the HHS risk transfer calculation to each member relative to the imputed market average; such that members with higher resulting relative transfer scores may have a receivable and members with lower resulting scores may have a payable, regardless of the net market risk transfer result. The resulting member transfers are summed to the HIOS plan level and adjusted for 2018 Risk Adjustment fees of \$0.18 PMPM in Worksheet 2.

#### Risk Adjustment – Projection Period

Aetna is projecting a risk adjustment receivable. We expect that we will have membership enrolled under the market average morbidity. The resulting PMPM adjustment, net of risk adjustment user fees, is \$20.05 PMPM.

#### **Reinsurance**

Transitional Reinsurance recoveries do not apply to Small Group business. The experience period data does not contain Reinsurance Contributions during 2018.

#### **Risk Corridor**

The Risk Corridor program does not apply to Small Group business.

#### **Past and Prospective Loss Experience Within and Outside the State**

The loss experience used in the development of the rates was based on the HMO Small Group Experience for Innovation Health Plan, Inc. and PPO Small Group Experience for Innovation Health Insurance Company in Northern Virginia.

#### **Reasonable Margin for Reserve Needs & Past and Prospective Expenses**

The retention portion of the projected premium is illustrated in Exhibit 5.

The prospective general and administrative expenses are based on historical corporate small group market expense levels, current-year projections, and projected changes in expenses, inflation, and membership for 2020. The commission expense factor covers anticipated sales and marketing expenses. Those may include, without limitation, purchase of television, internet and other advertising; payments of commissions and other incentive compensation to the Company's internal sales force; and payment of commissions to external brokers. The exact amounts and distribution among the categories of sales and marketing expenses will depend on a variety of factors including competitive conditions, business strategy, consumer behaviors, and legal and regulatory requirements. The consumer behaviors would capture whether they use a particular distribution channel, commissioned or not, as well as their experience.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2020, as well as Federal income tax. The risk adjustment user fee, as previously mentioned in the Risk Adjustment section, is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

The profit and risk load is consistent with the target used in the initial pricing for our 2019 plans.

#### **Any Other Relevant Factors Within and Outside the State**

All relevant Factors within and outside the State have been considered in the development of the proposed rates.

**Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8**

This filing is in conformity with all the applicable Actuarial Standards of Practice, including ASOP No. 8.

**Actuarial Certification**

I, Joanna Kluza, am an employee of Aetna Inc. and a member of the American Academy of Actuaries. I have reviewed the enclosed rates submitted by Aetna Health Inc. for the District of Columbia.

These rates reflect the negotiated prices from the provider contracts and the expected utilization experience of the plan.

I relied upon financial records and summaries prepared by responsible officers and employees of Aetna Health Inc. In other respects, my analysis included review of assumptions that I considered necessary.

For preparation of the rates, items identified above:

- (i). are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,
- (ii). meet the requirements of Washington D.C,
- (iii). make a good and sufficient provision for all unpaid claims of the organization under the terms of its contracts and agreements, and
- (iv). include appropriate provision for all actuarial items which ought to be established where allowed by law.

A target medical loss ratio of 77.9% was used for this filing calculated in the traditional way. The expected 2020 MLR for this filing, as defined by PPACA and before any credibility adjustment, is 85.2%.

These rates are appropriate for quotes delivered for effective dates beginning January 1, 2020. The proposed change is an increase greater than the 10% threshold and will trigger the federal review requirements as specified under 45 CFR Part 154.

This rate filing conforms to the benefit plan provisions required by the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010.

In my opinion, the enclosed rates are reasonable in relation to the anticipated experience of Aetna Health Inc. They are neither excessive nor inadequate, nor unfairly discriminatory.



---

Joanna Kluza, ASA, MAAA  
Aetna Health Inc.

May 24, 2019  
Date

**District of Columbia Small Group  
AHI (HMO plans) Loss Ratio History**

DOS	Membership	Claims	Premium*	Loss Ratio
01/01/2017	350	155,031	147,985	104.76%
02/01/2017	337	39,699	143,929	27.58%
03/01/2017	327	63,680	140,215	45.42%
04/01/2017	329	67,784	140,661	48.19%
05/01/2017	310	79,646	130,982	60.81%
06/01/2017	313	62,710	131,836	47.57%
07/01/2017	309	58,137	132,236	43.96%
08/01/2017	297	65,700	126,512	51.93%
09/01/2017	297	41,579	127,311	32.66%
10/01/2017	301	67,515	132,381	51.00%
11/01/2017	301	79,300	131,586	60.26%
12/01/2017	299	112,519	130,713	86.08%
01/01/2018	261	76,290	124,685	61.19%
02/01/2018	257	108,504	121,021	89.66%
03/01/2018	255	159,087	120,311	132.23%
04/01/2018	256	134,814	121,465	110.99%
05/01/2018	253	137,616	120,525	114.18%
06/01/2018	241	114,739	117,531	97.62%
07/01/2018	232	97,364	114,392	85.11%
08/01/2018	207	211,528	107,965	195.92%
09/01/2018	199	182,079	105,139	173.18%
10/01/2018	202	320,373	107,014	299.38%
11/01/2018	196	90,726	102,569	88.45%
12/01/2018	165	33,780	82,357	41.02%
<b>CY2017</b>	<b>3,770</b>	<b>893,300</b>	<b>1,616,347</b>	<b>55.27%</b>
<b>CY2018</b>	<b>2,724</b>	<b>1,666,898</b>	<b>1,344,974</b>	<b>123.94%</b>

\*Note: Premiums shown are not risk adjusted. The current estimate of the 2018 risk adjusted loss ratio is 98.2%.

**Certificate Form Names and Numbers**

<i>Form Name</i>	<i>Form Number</i>
HI DC SG HHIXCOC V004	HI SG HCOC-2020 04-HIX
HI DC HGrpAg V003	HI SG HGrpAg 03

**Schedule Form Names and Numbers**

<i>Form Name</i>	<i>Form Number</i>
HI DC SG-HIXSOB-14042181 V004	HI SG-SOB-HMO-14042181 04-HIX
HI DC SG-HIXSOB-14042176 V004	HI SG-SOB-HMO-14042176 04-HIX
HI DC SG-HIXSOB-14042177 V004	HI SG-SOB-HMO-14042177 04-HIX
HI DC SG-HIXSOB-14042182 V004	HI SG-SOB-HMO-14042182 04-HIX
HI DC SG-HIXSOB-14042179 V004	HI SG-SOB-HMO-14042179 04-HIX
HI DC SG-HIXSOB-14042188 V004	HI SG-SOB-HMO-14042188 04-HIX
HI DC SG-HIXSOB-14042180 V004	HI SG-SOB-HMO-14042180 04-HIX
HI DC SG-HIXSOB-14042178 V004	HI SG-SOB-HMO-14042178 04-HIX

**Aetna Health Inc. – District of Columbia**  
**1Q20 Filing - Small Group Business**  
**HIOS product ID: 73987DC004**  
**Actuarial Memorandum**

**Statement of Purpose for Filing**

This actuarial memorandum supports Aetna Health Inc. commercial base rates for District of Columbia small groups effective beginning January 1, 2020. The purpose of this memorandum is to comply with the District of Columbia, Department of Insurance, Securities and Banking, Health Insurance Rate Filing Procedures and to provide adequate supporting information for our proposed rates pursuant to the DC Official Code, Title 31, Subtitle IV, Chapter 34.

The requested rates have been developed incorporating consideration of the market changes and rating requirements taking effect in the Small Group market pursuant to the Patient Protection and Affordable Care Act of 2010 and subsequent regulation. They are compliant with all rating limitations under federal and state regulation. The plan designs contained in this submission are to be sold on the Exchange.

The descriptions and analyses presented in this rate filing reflect our current understanding of regulations and guidance. As further guidance is received, we reserve the right to submit revisions or withdraw this rate filing.

**Summary of Changes from prior filing and rate manual**

We are proposing to revise the quarterly premium rates for effective dates from January 1, 2020, through December 31, 2020. The quarterly rate increases are reflected in Exhibit 7. Generally, rate changes do not vary by plan design, with the exception of the impact associated with plan-specific benefit modifications necessary to comply with Actuarial Value requirements.

Rates for the plans in this submission are being revised to reflect 1) the impact of updated experience data and medical claim trend and 2) changes in cost-sharing levels to ensure that plans comply with Actuarial Value requirements.

There are no other proposed changes for this submission.

**Form Numbers**

An exhibit showing the Form Numbers is shown on under the "Certificate of Form Names and Numbers" Exhibit of this Actuarial Memorandum.

**Status of Forms**

The forms for this submission are "open to new sales" and "non-grandfathered".

**Description of Benefits/Metal Levels and Actuarial Values**

This filing covers HMO group medical benefit coverage. The range of coverage includes inpatient, outpatient, primary care, specialist services, pharmacy, DME, and vision. Information on the cost-sharing parameters of the covered benefit plans, including deductibles and copays, can be found in the Schedule of Benefits in the Form filing (AETN-131865435). All benefits are compliant with state mandates and the requirements of the Patient Protection and Affordable Care Act of 2010, including preventive care benefits, deductible limits, and Actuarial Value requirements.

Exhibit A shows the metal level and actuarial value for each plan design using the AV calculator developed and made available by HHS.

### Average Rate Increase Requested

The following tables provide the requested weighted average increases. The first table shows the incremental increase and the second table shows the year over year increase.

	1Q20/4Q19	2Q20/1Q20	3Q20/2Q20	4Q20/3Q20
<b>Incremental Rate Increase</b>	8.03%	2.95%	2.95%	2.95%

	1Q20/1Q19	2Q20/2Q19	3Q20/3Q19	4Q20/4Q19	Average
<b>Requested Rate Increase</b>	19.86%	19.20%	18.53%	17.86%	19.29%

### Maximum Rate Increase Requested

The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rate factors is 34.98%. This rate increase applies to members renewing in 1Q20 for the DC Bronze HNOOnly 6000 80% \$15/50 E plan (HIOS ID 73987DC0040056).

### Minimum Rate Increase Requested

The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rate factors is 6.17%. This rate increase applies to members renewing in 4Q20 for the DC Gold HNOOnly 1500 90% E plan (HIOS ID 73987DC0040058).

### Absolute Maximum Premium Increase

The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes like aging, is 47.54%. This rate increase applies to members renewing in 1Q20 for the DC Bronze HNOOnly 6000 80% \$15/50 E (HIOS ID 73987DC0040056) that age up from 20 to 21.

### Average Renewal Rate Increase for a Year

The average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing is 19.29%

### Rate Change History

The rate change history for the forms referenced in the filing is shown below.

Rate Effective Date	Annual Total Change
4Q18	8.7%
1Q19	1.7%
2Q19	2.6%
3Q19	3.5%
4Q19	4.4%

## Exposure

The current exposure as of December 2018 is 39 policies, 124 certificates, and 177 covered lives.

## Member Months

The numbers of members in force during each month of the base experience used in the rate development and for the preceding 12 month period for the forms referenced in this filing are shown in the Loss Ratio History Exhibit of the Actuarial Memorandum.

## Past Experience

The monthly earned premium and incurred claims for the base experience period used in the rate development and for the preceding 12 month period for the forms referenced in this filing are shown in the Loss Ratio History Exhibit of the Actuarial Memorandum.

## Index Rate

The index rate = \$566.75.

## Rate Development

### Determination of Claim Portion of Market Index Rate

In setting the projected claim level in the market in 2020, we based our projections upon the 2018 experience of our current ACA small group block of business for Innovation Health Plan, Inc. and Innovation Health Insurance Company, in the 2-50 market. The experience data utilized in the rate development reflects incurred claims from January 1, 2018 to December 31, 2018 and paid through February 2019. This manual experience is the HMO Small Group Experience for Innovation Health Plan, Inc. and PPO Small Group Experience for Innovation Health Insurance Company in Northern Virginia.

The manual experience used to develop the rates is shown below:

DOS	Membership	Claims	Premium *	Loss Ratio
01/01/2018	13,992	3,931,541	6,115,969	64.28%
02/01/2018	13,476	3,851,824	5,924,396	65.02%
03/01/2018	12,992	3,499,803	5,745,034	60.92%
04/01/2018	12,183	3,373,125	5,419,071	62.25%
05/01/2018	11,525	3,603,869	5,151,369	69.96%
06/01/2018	10,635	3,664,768	4,799,901	76.35%
07/01/2018	9,984	3,093,389	4,549,470	67.99%
08/01/2018	9,494	3,603,007	4,341,772	82.98%
09/01/2018	8,435	2,546,045	3,926,947	64.84%
10/01/2018	7,437	2,879,459	3,476,116	82.84%
11/01/2018	6,954	2,342,198	3,254,322	71.97%
12/01/2018	3,867	960,037	1,951,448	49.20%
<b>Total</b>	<b>120,974</b>	<b>37,349,065</b>	<b>54,655,817</b>	<b>68.34%</b>

\*Note: Premiums shown are not risk adjusted. The current estimate of the 2018 risk adjusted loss ratio is 71.1%.



Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects one month of paid claim run-off. The IBNP reserves account for approximately 0.31% of the experience period incurred claims.

For the projection, the following was taken into consideration:

A. Changes in the Morbidity of the Population Insured:

The experience period data includes experience for policies issued to small employers in 2017 and 2018. We considered the expected relationships between the morbidity of the experience policies and the likely population that will be covered by Small Group Single Risk Pool policies in 2020. This filing also includes adjustments to projected morbidity assuming the Small Group and Individual Market risk pools are combined for DC. These adjustments are based on a comparison of our Small Group risk scores versus the risk scores of what a merged market would look like using data from CCIO website, as well as the Wakeley study commissioned last year by DC.

B. Changes in Benefits:

The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for Single Risk Pool products that have essentially identical benefits.

The change in projected utilization due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.

C. Changes in Demographics:

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibits 2 and 3 contain detail on the calculations of the impact of demographic mix shifts.

D. Other Adjustments:

The 'Other' adjustment includes the projected impact of changes in network composition and provider contracts.

Determination of Retention Portion of Market Index Rate

The retention portion of the projected premium is illustrated in Exhibit 5.

The prospective general and administrative expenses are based on historical corporate small group market expense levels, current-year projections, and projected changes in expenses, inflation, and membership for 2020. The commission expense factor covers anticipated sales and marketing expenses. Those may include, without limitation, purchase of television, internet and other advertising; payments of commissions and other incentive compensation to Company's internal sales force; and payment of commissions to external brokers. The exact amounts and distribution among the categories of sales and marketing expenses will depend on a variety of factors including competitive conditions, business strategy, consumer behaviors, and legal and regulatory requirements. The consumer

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Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2020, as well as Federal income tax. The risk adjustment user fee is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

The profit and risk load is consistent with the target used in our initial pricing of 2019.

### **Requested Rates**

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three dependents under age 21, only the three oldest dependents will be considered in determining the family's premium. Additional dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:

Calibrated Plan Adjusted Index Rate \* Age Factor \* Area Factor \* Trend Factor

The resulting rate is rounded to the nearest cent, and rates are then summed for all billable family members.

An example of a contract's premium determined by the member build-up calculation is shown in Exhibit 9.

### **Credibility Assumption**

Experience data for the District of Columbia is assigned 23% credibility.

### **Trend Assumption**

Anticipated annual trend from the experience period to the rating period for the product line is shown in the following table. The table shows the trend assumptions by major types of service as defined by HHS, separately by unit cost, utilization, and in total.

<b>Type of Service</b>	<b>Unit Cost</b>	<b>Utilization</b>	<b>Total</b>
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Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

#### **b. Pharmacy Trend**

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The Plan Relativities represent the expected value of the difference in benefits and networks between the market index rate and each additional proposed benefit plan discussed in this filing. The relativities were developed using a proprietary pricing model which relies on State- and product-specific benefit service category weights and rating factors for various levels of plan/member cost-sharing options for deductibles, coinsurance, out-of-pocket maximums and copays.

The product-specific service category weights were developed based on the experience of Aetna's Small Group block of business. The cost-sharing-specific rating factors were developed using experience associated with our Large Group block of business, which excludes the effects of selection. These Large Group based cost-sharing specific rating factors account for differences in a standard population's spending patterns due to differences in the richness and/or structure of benefits, or induced demand, without reflection of differences in health status.

Final plan relativities reflect the value of the EHB and state mandated benefits (including pediatric dental), incorporating the impact of out-of-network benefits and additional benefits. The methodology also considers the value of any differences in network by plan, including but not limited to network discounts and steerage.

The Plan Relativities for each plan are shown in the AV Pricing Value Column of Exhibit E-2.

### **Rating Factors**

#### Effective Date Factors

Exhibit 7 illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. Trend factors are developed from annual forward trend, and leveraging. A trend factor of 1.00 corresponds to a policy period that begins January 1, 2020.

#### Member Age Factor

The age factors are based on the DC specific age scale. The factors are shown in Exhibit 11.

#### Tobacco Factors

No load is proposed for tobacco users.

#### Area Factors

Exhibit 3 summarizes the rating area definitions and factors, and displays the projected membership by area to develop the projected average area factor. The geographic calibration factor is the reciprocal of the projected average area factor.

### **Wellness Programs**

Aetna may encourage and incent members to access certain medical services, to use online tools that enhance their coverage and services, and to continue participation as an **Aetna** member. Members and their doctor can talk about these medical services and decide if they are right for the member. Aetna may also encourage and incent members in connection with participation in a wellness or health improvement program. Incentives include but are not limited to:

- Modification to **copayment, deductible** or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health.

### **Distribution of Rate Increases**

The distribution of rate increases (annual) is shown in Exhibit A-1. The increases are shown by Plan.

### **Claim Reserve Needs**

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

The experience data reflects incurred claims from January 1, 2018 through December 31, 2018 and paid through February 28, 2019. The paid claims for the DC Base experience period are \$1,661,807. The estimated incurred claims are \$1,666,898.

### **Administrative Costs of Programs that Improve Health Care Quality**

The administrative costs included with claims in the numerator of the MLR calculation are shown in Exhibit 6 (MLR Projection).

### **Taxes and Licensing or Regulatory Fees**

The taxes, licenses and fees removed from premium in the denominator of the MLR calculation are shown in Exhibit 6 (MLR Projection).

### **Medical Loss Ratio (MLR)**

The projected Medical Loss Ratio (MLR) as defined by HHS is 85.5% and meets the minimum MLR requirements of Insurance Art. § 15-605(c). The details of the MLR calculation are shown in Exhibit 6 (MLR Projection).

### **Risk Adjustment**

### Risk Adjustment – Experience Period

Risk Adjustment transfer based on 2018 Wakely Accruals. The transfer is allocated to the member-level based by applying the HHS risk transfer calculation to each member relative to the inputted market average; such that members with higher resulting relative transfer scores may have a receivable and members with lower resulting scores may have a payable, regardless of the net market risk transfer result. The resulting member transfers are summed to the HIOS plan level and adjusted for 2018 Risk Adjustment fees of \$0.18 PMPM in Worksheet 2.

### Risk Adjustment – Projection Period

Aetna is projecting a risk adjustment receivable. We expect that we will have membership enrolled under the market average morbidity. The resulting PMPM adjustment, net of risk adjustment user fees, is \$20.01 PMPM.

### **Reinsurance**

Transitional Reinsurance recoveries do not apply to Small Group business. The experience period data does not contain Reinsurance Contributions during 2018.

### **Risk Corridor**

The Risk Corridor program does not apply to Small Group business.

### **Past and Prospective Loss Experience Within and Outside the State**

The loss experience used in the development of the rates was based on the HMO Small Group Experience for Innovation Health Plan, Inc. and PPO Small Group Experience for Innovation Health Insurance Company in Northern Virginia.

### **Reasonable Margin for Reserve Needs & Past and Prospective Expenses**

The retention portion of the projected premium is illustrated in Exhibit 5.

The prospective general and administrative expenses are based on historical corporate small group market expense levels, current-year projections, and projected changes in expenses, inflation, and membership for 2020. The commission expense factor covers anticipated sales and marketing expenses. Those may include, without limitation, purchase of television, internet and other advertising; payments of commissions and other incentive compensation to the Company's internal sales force; and payment of commissions to external brokers. The exact amounts and distribution among the categories of sales and marketing expenses will depend on a variety of factors including competitive conditions, business strategy, consumer behaviors, and legal and regulatory requirements. The consumer behaviors would capture whether they use a particular distribution channel, commissioned or not, as well as their experience.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2020, as well as Federal income tax. The risk adjustment user fee, as previously mentioned in the Risk Adjustment section, is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

The profit and risk load is consistent with the target used in the initial pricing for our 2019 plans.

### **Any Other Relevant Factors Within and Outside the State**

All relevant Factors within and outside the State have been considered in the development of the proposed rates.

**Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8**

This filing is in conformity with all the applicable Actuarial Standards of Practice, including ASOP No. 8.

**Actuarial Certification**

I, Joanna Kluza, am an employee of Aetna Inc. and a member of the American Academy of Actuaries. I have reviewed the enclosed rates submitted by Aetna Health Inc. for the District of Columbia.

These rates reflect the negotiated prices from the provider contracts and the expected utilization experience of the plan.

I relied upon financial records and summaries prepared by responsible officers and employees of Aetna Health Inc. In other respects, my analysis included review of assumptions that I considered necessary.

For preparation of the rates, items identified above:

- (i). are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,
- (ii). meet the requirements of Washington D.C,
- (iii). make a good and sufficient provision for all unpaid claims of the organization under the terms of its contracts and agreements, and
- (iv). include appropriate provision for all actuarial items which ought to be established where allowed by law.

A target medical loss ratio of 78.2% was used for this filing calculated in the traditional way. The expected 2020 MLR for this filing, as defined by PPACA and before any credibility adjustment, is 85.5%.

These rates are appropriate for quotes delivered for effective dates beginning January 1, 2020. The proposed change is an increase greater than the 10% threshold and will trigger the federal review requirements as specified under 45 CFR Part 154.

This rate filing conforms to the benefit plan provisions required by the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010.

In my opinion, the enclosed rates are reasonable in relation to the anticipated experience of Aetna Health Inc. They are neither excessive nor inadequate, nor unfairly discriminatory.



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Joanna Kluza, ASA, MAAA  
Aetna Health Inc.

May 24, 2019  
Date

**District of Columbia Small Group  
AHI (HMO plans) Loss Ratio History**

DOS	Membership	Claims	Premium*	Loss Ratio
01/01/2017	350	155,031	147,985	104.76%
02/01/2017	337	39,699	143,929	27.58%
03/01/2017	327	63,680	140,215	45.42%
04/01/2017	329	67,784	140,661	48.19%
05/01/2017	310	79,646	130,982	60.81%
06/01/2017	313	62,710	131,836	47.57%
07/01/2017	309	58,137	132,236	43.96%
08/01/2017	297	65,700	126,512	51.93%
09/01/2017	297	41,579	127,311	32.66%
10/01/2017	301	67,515	132,381	51.00%
11/01/2017	301	79,300	131,586	60.26%
12/01/2017	299	112,519	130,713	86.08%
01/01/2018	261	76,290	124,685	61.19%
02/01/2018	257	108,504	121,021	89.66%
03/01/2018	255	159,087	120,311	132.23%
04/01/2018	256	134,814	121,465	110.99%
05/01/2018	253	137,616	120,525	114.18%
06/01/2018	241	114,739	117,531	97.62%
07/01/2018	232	97,364	114,392	85.11%
08/01/2018	207	211,528	107,965	195.92%
09/01/2018	199	182,079	105,139	173.18%
10/01/2018	202	320,373	107,014	299.38%
11/01/2018	196	90,726	102,569	88.45%
12/01/2018	165	33,780	82,357	41.02%
<b>CY2017</b>	<b>3,770</b>	<b>893,300</b>	<b>1,616,347</b>	<b>55.27%</b>
<b>CY2018</b>	<b>2,724</b>	<b>1,666,898</b>	<b>1,344,974</b>	<b>123.94%</b>

\*Note: Premiums shown are not risk adjusted. The current estimate of the 2018 risk adjusted loss ratio is 98.2%.

**Certificate Form Names and Numbers**

<i>Form Name</i>	<i>Form Number</i>
HI DC SG HHIXCOC V004	HI SG HCOC-2020 04-HIX
HI DC HGrpAg V003	HI SG HGrpAg 03

**Schedule Form Names and Numbers**

<i>Form Name</i>	<i>Form Number</i>
HI DC SG-HIXSOB-14042181 V004	HI SG-SOB-HMO-14042181 04-HIX
HI DC SG-HIXSOB-14042176 V004	HI SG-SOB-HMO-14042176 04-HIX
HI DC SG-HIXSOB-14042177 V004	HI SG-SOB-HMO-14042177 04-HIX
HI DC SG-HIXSOB-14042182 V004	HI SG-SOB-HMO-14042182 04-HIX
HI DC SG-HIXSOB-14042179 V004	HI SG-SOB-HMO-14042179 04-HIX
HI DC SG-HIXSOB-14042188 V004	HI SG-SOB-HMO-14042188 04-HIX
HI DC SG-HIXSOB-14042180 V004	HI SG-SOB-HMO-14042180 04-HIX
HI DC SG-HIXSOB-14042178 V004	HI SG-SOB-HMO-14042178 04-HIX



## Actuarial Memorandum and Certification

### General Information

#### *Company Identifying Information:*

<b>Company Legal Name:</b>	<b>Aetna Health Inc.</b>
<b>State:</b>	<b>District of Columbia</b>
<b>HIOS Issuer ID:</b>	<b>73987</b>
<b>Market:</b>	Small Group
<b>Effective Date:</b>	01/01/2020
<b>Rate Filing Tracking Number:</b>	<b>AETN-131944461</b>
<b>Policy Form(s):</b>	
<b>Form Filing Tracking Number:</b>	<b>AETN-131865435</b>

#### *Company Contact Information:*

<b>Name:</b>	<b>Joanna Kluza</b>
<b>Telephone Number:</b>	<b>(860)273-3099</b>
<b>Email Address:</b>	<b>KluzaJ@aetna.com</b>

### 1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

- 1) Provide support for the development of the Part I Unified Rate Review Template;
- 2) Provide support for the assumptions and premiums rate development for the products supported by the policy forms referenced above;
- 3) Request approval of the proposed monthly premium rates; and
- 4) Provide benefit plan designs summaries for the products included in this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.

These rates are for plans issued in District of Columbia beginning January 1, 2020. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be offered outside the public Marketplace in District of Columbia.

### 2. Proposed Rate Increase

Monthly premium rates for Small Group Market products in District of Columbia are being revised for effective dates January 1, 2020 through December 31, 2020.

#### A. Reason for Rate Increase(s):

- Impact of medical claim trend (including changes in provider unit costs and increased utilization of medical cost services) and pharmacy trend;
- Revisions to our assumptions about market-wide population morbidity and the projected population distribution;
- Re-instatement of the Health Insurers Fee after a 1-year hiatus in 2019;
- Revisions to administrative expense projections;
- Modifications in cost sharing to ensure that plans comply with Actuarial Value requirements;
- Updates to our pricing models used to determine the impact of cost sharing designs;

- Changes in provider networks and contracts.
- Expansion of definition for Small Group eligibility down to one sole proprietor

B. Variation in Rate Changes by Plan/Product:

Rate changes differ by plan for the following reasons:

- Provider cost estimates have been updated, and the change differs by network.
- Modification to cost sharing differs by plan in order to maintain compliance with Actuarial Value and other regulatory requirements.
- Our internal pricing models have been updated to reflect more current information on levels of induced demand associated with different benefit designs. These changes impact our estimates of the relative costs of the plan designs that will be offered.

Exhibit 1 shows the average threshold increases for products covered by this filing.

3. Experience Period Premium and Claims

A. Paid Through Date:

The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2018 through December 31, 2018 and paid through February 2019.

B. Premiums (Net of MLR Rebate) in Experience Period:

Experience period premiums are date-of-service premiums from our actuarial experience databases for non-grandfathered Small Group business in District of Columbia. Our internal projections indicate that no MLR rebate is expected to be paid in 2018 (for 2017 experience) for the Small Group MLR Pool in District of Columbia. As such, no adjustment was made to premiums to account for expected rebates.

C. Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level detail on total allowed and incurred claims but do not include unit cost or utilization metrics. We allocate claims to cost categories and estimate the corresponding unit costs and utilization metrics by using an alternate reporting system that calculates unit cost and utilization metrics by medical cost category but only permits inclusion/exclusion of experience at the market and segment levels. A reconciliation of aggregate data in our actuarial experience databases is performed to ensure that data is consistent with the experience data contained in our enterprise-wide data warehouse.

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects two months of paid claim run-off. The IBNP reserves account for approximately 0.31% of the experience period incurred claims.

4. Benefit Categories

Our internal systems assign claims to several benefit categories. We have mapped these categories to the categories described in the Unified Rate Review Instructions released in April 2019. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, including day-based mental health services. Outpatient Hospital includes outpatient surgical, outpatient mental health, and emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses, including office-based mental health services. Other includes dental, home health care, medical pharmacy expenses, laboratory expenses, and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

## 5. Projection Factors

### A. Changes in the Morbidity of the Population Insured:

The experience period data includes experience for community-rated policies issued to small employers in 2018.

We also considered the expected morbidity of the DC small group ACA population and the likely population that will be covered by Small Group Single Risk Pool policies in 2020 and have adjusted our projections for this morbidity change accordingly.

### B. Plan Design Changes:

The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for Single Risk Pool products that have essentially identical benefits and coverage.

The change in projected utilization due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.

### C. Changes in Demographics:

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibits 2 and 3 contain detail on the calculations of the impact of demographic mix shifts.

### D. Other Adjustments:

The 'Other' adjustment includes the projected impact of changes in network composition and provider contracts, expected morbidity changes, changes in benefits, and changes in demographics.

### E. Trend Factors (Cost/Utilization):

Medical trend factors are based on our Medical Economics Unit's national guidance coupled with local trend and network experience, based on analysis of a continuous normalized population, excluding catastrophic claims. Allowed medical trend includes known and anticipated changes in provider contract

rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

Pharmacy trends are based on national commercial group Rx trend analysis. Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. Pharmacy Trend is expressed in terms of allowed trend less rebates.

Exhibit 8 shows the anticipated annual trend from the experience period to the rating period.

## 6. Manual Rate Adjustments:

### A. Source and Appropriateness of Experience Data Used:

The source data for our manual rate is the experience incurred from January 1, 2018 to December 31, 2018 and paid through February 2019 for issuers 12028 and 86443 in the Virginia Small Group HMO & PPO market. The Small Group market experience is considered an appropriate source for the manual rate due to similarities in covered benefits and market dynamics to the current ACA Small Group market. The similar dynamics include: no individual medical underwriting and rating by gender, limits on age-rating, and caps for rating on the number of dependents, as well as plans benefits and cost-sharing.

### B. Adjustments Made to the Data:

The Small Group experience used as the basis for the manual rate was adjusted in a similar manner as the base period experience for changes in population risk morbidity, benefits, and demographic and area normalizations. The data is further adjusted for projected changes in network, provider contract rates, and claims adjudication, in addition to unit cost and utilization trend.

### C. Inclusion of Capitation Payments:

No services provided in 2020 will be covered by capitation arrangements. We have adjusted the experience data to incorporate our best-estimate of the impact of moving to fee for service payment approaches.

## 7. Credibility of Experience

The CMS Medicare full credibility standard is 24,000 member months. Based on our experience, the Medicare population has significantly higher utilization than Commercial populations. Using actuarial judgement, we have assigned 23% credibility to experience data.

## 8. Risk Adjustment

### A. Risk Adjustment – Experience Period

Risk Adjustment transfer is accrued at the issuer and market level based on 2018 Wakely data and our internal projections of how our risk relative to market has changed since that report was issued. The transfer is allocated to the member-level based by applying the HHS risk transfer calculation to each member relative to the imputed market-average, such that members with higher resulting relative transfers scores may have a receivable and members with lower resulting scores may have a payable, regardless of the net market risk transfer result. The resulting member transfers are summed to the HIOS plan level.

### B. Risk Adjustment – Projection Period

We started with 2018 Risk Adjustment accruals to determine our current risk transfer relative to the market. The difference between our projected relative risk and the market's is trended for two years.

In addition, the projected risk adjustment transfer includes changes that were outlined in the 2019 Notice of Benefit and Payment Parameters. The 2020 projected market average premium used in the payment transfer formula is also reduced by 14% to remove administrative cost

As a result, we project a risk adjustment receivable, net of the 2020 user fee of \$0.18 PBMPM. The resulting PMPM adjustment, net of risk adjustment user fees, is \$20.05.

#### 9. Non-Benefit Expenses and Profit & Risk

The retention portion of the projected premium is illustrated in Exhibit 5.

Actual general and administrative expenses are based on historical corporate Small Group market expense levels, 2020 projections, and projected changes in expenses, inflation, and membership for 2020 for our National book of Small Group business.

A flat commission per policy per month will be paid to all brokers in DC during open enrollment. Commissions do not vary by plan.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2020, as well as Federal income tax and State Premium taxes. The risk adjustment user fee, as previously mentioned in Section 9, is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

The profit and risk load is consistent with the target used in our original pricing of our 2019 plans. This represents a 3% increase in profit over the final approved filing from last year.

#### 10. Projected Loss Ratio

The expected 2020 MLR for this filing, as defined by PPACA and before any credibility adjustment, is shown in Exhibit 6.

#### 11. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Small Group market in the District of Columbia through Aetna Health Inc.. The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d).

#### 12. Index Rate

The index rates for the experience and projection periods are set equal to the actual and projected allowed claims, respectively, less non-essential health benefits.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are based on our internal company modeling of plan cost-sharing designs, the plan's provider network, delivery system characteristics, and utilization management practices, the impacts (as applicable) of benefits in addition to EHBs catastrophic eligibility criteria, and the distribution and administrative costs applicable to the plan/product. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR 156 §156.80(d)(2).

**Small Group Market Trend Adjustments:** Exhibit 7 illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. Trend factors are developed from annual forward trend and leveraging. A trend factor of 1.00 corresponds to a policy period that begins January 1, 2020.

#### 13. Market-Adjusted Index Rate

Exhibit E-1 illustrates the development of the Market Adjusted Index Rate. The market-wide adjustment for Risk Adjustment was discussed, previously. The risk adjustment is displayed on a paid-basis and the

exchange user fee is estimated as a PMPM based on the target premium rate on Worksheet 1 of the URRT.

#### 14. Plan-Adjusted Index Rates

Exhibit E-2 illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The 2020 Plan Adjusted Index Rates are displayed in Column 7. The following briefly describes how each set of adjustments was determined.

##### A. Actuarial Value, Cost Sharing:

The factors in Column 2 are the product of two separate adjustments:

1. We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. The combination of these two analyses is a projection of the relative paid to allowed ratio which also reflects the impact of out of network coverage.
2. We applied an adjustment for the impact different levels of cost sharing have on the use of medical services, which is based in part on the induced utilization factors used in the Risk Adjustment program. These adjustments are first normalized to result in an aggregate factor of 1.0 when applied to the projected 2020 membership.

##### B. Distribution and Administrative Costs:

Exhibit E-2, Column 3, reflects the adjustment for projected administrative costs, including sales, marketing, any commission expense, profit, and risk. These are discussed above in the 'Non-Benefit Expenses and Profit & Risk' section, excluding the Risk Adjustment User Fee, and the Exchange User Fee, which are reflected in the Market-Adjusted Index Rate. These expense and profit assumptions do not vary by plan.

##### C. Provider Network, Delivery System, and Utilization Management:

The factors in Column 4 reflect the impact of differences in the network size, efficiency, and provider contract terms. We worked with our contracting area and other subject matter experts to review the impact of these differences and the expected impact on allowed claims.

##### D. Benefits in addition to EHBs:

The factors in Column 5 adjust for the impact of benefits in addition to EHBs.

##### E. Catastrophic Plan Eligibility:

This filing does not include catastrophic plans.

##### F. Experience Period Plan Adjusted Index Rates:

Worksheet 2 of the URRT displays the Plan Adjusted Index Rates filed in 2018 for the experience period.

#### 15. Calibration

##### A. Age Curve Calibration:

The age factors are based on the HHS Default Standard Age curve. We then project a premium-weighted average age factor for the 2020 membership using the prescribed age curve and the projected age distribution. The calibration factor is the reciprocal of this weighted average factor. The age that most closely corresponds to the premium weighted overall average age factor is the average age for the single risk pool.

##### B. Geographic Factor Calibration:

Projected area factors are shown in Exhibit 3. Unit cost trend studies were used to evaluate whether there were significant changes to network costs that would require changes from previously filed rating area factors. The geographic calibration factor is the reciprocal of the projected average area factor

#### C. Tobacco Factor Calibration

We are not applying a tobacco factor in our rating.

#### 16. Consumer-Adjusted Premium Rate Development

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three child dependents under age 21, only the three oldest child dependents will be considered in determining the family's premium. Additional child dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:

Calibrated Plan Adjusted Index Rate \* Age Factor \* Area Factor \* Trend Factor

The resulting rate is rounded to the nearest cent, and rates are then summed for all billable family members.

An example of a contract's premium determined by the member build-up calculation for a family of six, with more than three dependents under age 21, is shown in Exhibit 9.

#### 17. Composite Premiums

Small employers will be able to elect to have rates set using a composite approach as permitted by DC.

#### 18. AV Metal Values

The AV Metal Values on Worksheet 2 were based on the AV 2020 Calculator. As applicable, entries were modified to reflect the plan appropriately and/or adjustments were made for plan design features that could not be entered in the calculator per 45 CFR Part 156, §156.135. The accompanying certification discusses how the benefits were modified to fit the parameters and the development of any adjustments. The AV screen shots provide detail on the modified entries and adjustments to AV, as applicable.

#### 19. AV Pricing Values

The AV Pricing Values are calculated as the ratio of the Plan Adjusted Index Rate to the Market Adjusted Index Rate. The adjustments reflected in the AV Pricing Values are discussed in Section 15. AV Pricing Values do not differ based on morbidity differences or benefit selection anticipated within the Single Risk Pool.

#### 20. Membership Projections

Exhibit A summarizes the membership distribution by plan. Membership projections on Worksheet 2 are based on historical experience, enrollment in ACA-compliant plans through January 2019, and our expectations for future sales as additional members move to these plans from grandfathered and transitional plans.

#### Terminated Plans and Products

Exhibit 10 provides a plan and product crosswalk from 2018 to 2020. The crosswalk includes the list of products that have experience in the single risk pool experience period, and products that were made available in 2019 and 2020.

Consistent with the URRT instructions, experience for non-single risk pool terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

21. Plan Type

All plans are consistent with the plan type indicated on Worksheet 2.

22. Benefit Design

This filing includes one Bronze, three Silver, and four Gold plans.

Please refer to the corresponding policy forms for detailed benefit language. Exhibit A-2 provides the screenshots from the AV Calculator. All benefit and cost sharing parameters comply with DC benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

23. Marketing

Plans will be available outside of the public Marketplace. These plans may be marketed in a variety of means, including HHS Planfinder and our own website. In addition, members of our 2018 plans will be mailed a discontinuance or renewal letter, in accordance with CMS guidelines. Marketing and distribution approaches may change from time to time at management's discretion.

24. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations.

25. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

26. Company Financial Condition

As of December 31, 2018, the capital and surplus held by Aetna Health Inc. was approximately \$489.5 million. This amount is disclosed in page 3, line 33 of the Company's statutory financial statement dated December 31, 2018. The Company issues insurance nationwide for multiple lines of business including, large group medical, Small Group medical, and various non-medical products.

Reliance

While I have reviewed the reasonableness of the assumptions and data in support of both the preparation of the Part I Unified Rate Review Template and the rate development applicable to the products discussed in this filing, I relied on the expertise of other Aetna employees, along with work products produced at their direction, for the following items:

- Experience Period MLR Rebates
- Risk Adjustment Transfer
- Actuarial Value, Modifications, and Benefit Relativities
- Supplemental EHB Pricing
- Population Risk Morbidity
- Medical Cost and Utilization Trend
- Rx Cost and Utilization Trend
- Components of Retention/Administrative Fees
- Value of Network Arrangements
- MH Net Trend
- Experience Period Data – Small Group



### Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated marketplaces, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, Joanna Kluza, am an Associate of the Society of Actuaries, a member of the American Academy of Actuaries, and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the District of Columbia, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:
  - a. ASOP No. 5, Incurred Health and Disability Claims
  - b. ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health
  - c. ASOP No. 12, Risk Classification
  - d. ASOP No. 23, Data Quality
  - e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
  - f. ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
  - g. ASOP No. 41, Actuarial Communications
  - h. ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act
2. The Projected Index Rate is:
  - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1) and 147.102),
  - b. Developed in compliance with the applicable Actuarial Standards of Practice,
  - c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
  - d. Neither excessive, deficient, nor unfairly discriminatory.
3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
5. The geographic rating factors reflect only differences in the costs of delivery (which include unit costs and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

6. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments made to reflect benefit features not handled by the AV Calculator are discussed in the attached certification required by 45 CFR Part 156, §156.135.



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Joanna Kluza, ASA, MAAA  
Aetna Health Inc.

May 24, 2019

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Date

## Actuarial Memorandum and Certification

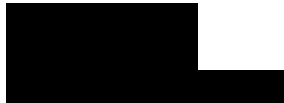
### General Information

#### *Company Identifying Information:*

**Company Legal Name:** Aetna Health Inc.  
**State:** District of Columbia  
**HIOS Issuer ID:** 73987  
**Market:** Small Group  
**Effective Date:** 01/01/2020  
**Rate Filing Tracking Number:** AETN-131944461  
**Policy Form(s):**  
**Form Filing Tracking Number:** AETN-131865435

#### *Company Contact Information:*

**Name:**  
**Telephone Number:**  
**Email Address:**



### 1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

- 1) Provide support for the development of the Part I Unified Rate Review Template;
- 2) Provide support for the assumptions and premiums rate development for the products supported by the policy forms referenced above;
- 3) Request approval of the proposed monthly premium rates; and
- 4) Provide benefit plan designs summaries for the products included in this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation. These rates are for plans issued in District of Columbia beginning January 1, 2020. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be offered outside the public Marketplace in District of Columbia.

### 2. Proposed Rate Increase

Monthly premium rates for Small Group Market products in District of Columbia are being revised for effective dates January 1, 2020 through December 31, 2020.

#### A. Reason for Rate Increase(s):

- Impact of medical claim trend (including changes in provider unit costs and increased utilization of medical cost services) and pharmacy trend;
- Revisions to our assumptions about market-wide population morbidity and the projected population distribution;
- Re-instatement of the Health Insurers Fee after a 1-year hiatus in 2019;
- Revisions to administrative expense projections;
- Modifications in cost sharing to ensure that plans comply with Actuarial Value requirements;
- Updates to our pricing models used to determine the impact of cost sharing designs;

- Changes in provider networks and contracts.
- Expansion of definition for Small Group eligibility down to one sole proprietor

B. Variation in Rate Changes by Plan/Product:

Rate changes differ by plan for the following reasons:

- Provider cost estimates have been updated, and the change differs by network.
- Modification to cost sharing differs by plan in order to maintain compliance with Actuarial Value and other regulatory requirements.
- Our internal pricing models have been updated to reflect more current information on levels of induced demand associated with different benefit designs. These changes impact our estimates of the relative costs of the plan designs that will be offered.

Exhibit 1 shows the average threshold increases for products covered by this filing.

3. Experience Period Premium and Claims

A. Paid Through Date:

The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2018 through December 31, 2018 and paid through February 2019.

B. Premiums (Net of MLR Rebate) in Experience Period:

Experience period premiums are date-of-service premiums from our actuarial experience databases for non-grandfathered Small Group business in District of Columbia. [REDACTED]

C. Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level detail on total allowed and incurred claims but do not include unit cost or utilization metrics. We allocate claims to cost categories and estimate the corresponding unit costs and utilization metrics by using an alternate reporting system that calculates unit cost and utilization metrics by medical cost category but only permits inclusion/exclusion of experience at the market and segment levels. A reconciliation of aggregate data in our actuarial experience databases is performed to ensure that data is consistent with the experience data contained in our enterprise-wide data warehouse.

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects two months of paid claim run-off. [REDACTED]

4. Benefit Categories

Our internal systems assign claims to several benefit categories. We have mapped these categories to the categories described in the Unified Rate Review Instructions released in April 2019. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, including day-based mental health services. Outpatient Hospital includes outpatient surgical, outpatient mental health, and emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses, including office-based mental health services. Other includes dental, home health care, medical pharmacy expenses, laboratory expenses, and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

## 5. Projection Factors

### A. Changes in the Morbidity of the Population Insured:

The experience period data includes experience for community-rated policies issued to small employers in 2018.

We also considered the expected morbidity of the DC small group ACA population and the likely population that will be covered by Small Group Single Risk Pool policies in 2020 and have adjusted our projections for this morbidity change accordingly.

### B. Plan Design Changes:

The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for Single Risk Pool products that have essentially identical benefits and coverage.

The change in projected utilization due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.

### C. Changes in Demographics:

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibits 2 and 3 contain detail on the calculations of the impact of demographic mix shifts.

### D. Other Adjustments:

The 'Other' adjustment includes the projected impact of changes in network composition and provider contracts, expected morbidity changes, changes in benefits, and changes in demographics.

### E. Trend Factors (Cost/Utilization):

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

6. Manual Rate Adjustments:

A. Source and Appropriateness of Experience Data Used:

[REDACTED]

B. Adjustments Made to the Data:

[REDACTED]

C. Inclusion of Capitation Payments:

[REDACTED]

7. Credibility of Experience

[REDACTED]

8. Risk Adjustment

A. Risk Adjustment – Experience Period

[REDACTED]

B. Risk Adjustment – Projection Period

[REDACTED]

[REDACTED]

9. Non-Benefit Expenses and Profit & Risk

Actual general and administrative expenses are based on historical corporate Small Group market expense levels, 2020 projections, and projected changes in expenses, inflation, and membership for 2020 for our National book of Small Group business.

A flat commission per policy per month will be paid to all brokers in DC during open enrollment. Commissions do not vary by plan.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2020, as well as Federal income tax and State Premium taxes. The risk adjustment user fee, as previously mentioned in Section 9, is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

10. Projected Loss Ratio

11. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Small Group market in the District of Columbia through Aetna Health Inc.. The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d).

12. Index Rate

The index rates for the experience and projection periods are set equal to the actual and projected allowed claims, respectively, less non-essential health benefits.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are based on our internal company modeling of plan cost-sharing designs, the plan's provider network, delivery system characteristics, and utilization management practices, the impacts (as applicable) of benefits in addition to EHBs catastrophic eligibility criteria, and the distribution and administrative costs applicable to the plan/product. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR 156 §156.80(d)(2).

**Small Group Market Trend Adjustments:**

13. Market-Adjusted Index Rate

14. Plan-Adjusted Index Rates

A. Actuarial Value, Cost Sharing:

The factors in Column 2 are the product of two separate adjustments:

B. Distribution and Administrative Costs:

C. Provider Network, Delivery System, and Utilization Management:

D. Benefits in addition to EHBs:

E. Catastrophic Plan Eligibility:

This filing does not include catastrophic plans.

F. Experience Period Plan Adjusted Index Rates:

Worksheet 2 of the URRT displays the Plan Adjusted Index Rates filed in 2018 for the experience period.

15. Calibration

A. Age Curve Calibration:

B. Geographic Factor Calibration:



C. Tobacco Factor Calibration

We are not applying a tobacco factor in our rating.

16. Consumer-Adjusted Premium Rate Development

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three child dependents under age 21, only the three oldest child dependents will be considered in determining the family's premium. Additional child dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:

Calibrated Plan Adjusted Index Rate \* Age Factor \* Area Factor \* Trend Factor

The resulting rate is rounded to the nearest cent, and rates are then summed for all billable family members.

17. Composite Premiums

Small employers will be able to elect to have rates set using a composite approach as permitted by DC.

18. AV Metal Values

The AV Metal Values on Worksheet 2 were based on the AV 2020 Calculator. As applicable, entries were modified to reflect the plan appropriately and/or adjustments were made for plan design features that could not be entered in the calculator per 45 CFR Part 156, §156.135. The accompanying certification discusses how the benefits were modified to fit the parameters and the development of any adjustments. The AV screen shots provide detail on the modified entries and adjustments to AV, as applicable.

19. AV Pricing Values

The AV Pricing Values are calculated as the ratio of the Plan Adjusted Index Rate to the Market Adjusted Index Rate. The adjustments reflected in the AV Pricing Values are discussed in Section 15. AV Pricing Values do not differ based on morbidity differences or benefit selection anticipated within the Single Risk Pool.

20. Membership Projections

Terminated Plans and Products

Exhibit 10 provides a plan and product crosswalk from 2018 to 2020. The crosswalk includes the list of products that have experience in the single risk pool experience period, and products that were made available in 2019 and 2020.

Consistent with the URRT instructions, experience for non-single risk pool terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

21. Plan Type

All plans are consistent with the plan type indicated on Worksheet 2.

22. Benefit Design

This filing includes one Bronze, three Silver, and four Gold plans.

Please refer to the corresponding policy forms for detailed benefit language. Exhibit A-2 provides the screenshots from the AV Calculator. All benefit and cost sharing parameters comply with DC benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

23. Marketing

Plans will be available outside of the public Marketplace. These plans may be marketed in a variety of means, including HHS Planfinder and our own website. In addition, members of our 2018 plans will be mailed a discontinuance or renewal letter, in accordance with CMS guidelines. Marketing and distribution approaches may change from time to time at management's discretion.

24. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations.

25. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

26. Company Financial Condition

[REDACTED]

Reliance

While I have reviewed the reasonableness of the assumptions and data in support of both the preparation of the Part I Unified Rate Review Template and the rate development applicable to the products discussed in this filing, I relied on the expertise of other Aetna employees, along with work products produced at their direction, for the following items:

[REDACTED]

Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated marketplaces, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, [REDACTED], am an [REDACTED], and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the District of Columbia, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:
  - a. ASOP No. 5, Incurred Health and Disability Claims
  - b. ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health
  - c. ASOP No. 12, Risk Classification
  - d. ASOP No. 23, Data Quality
  - e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
  - f. ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
  - g. ASOP No. 41, Actuarial Communications
  - h. ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act
2. The Projected Index Rate is:
  - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1) and 147.102),
  - b. Developed in compliance with the applicable Actuarial Standards of Practice,
  - c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
  - d. Neither excessive, deficient, nor unfairly discriminatory.
3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
5. The geographic rating factors reflect only differences in the costs of delivery (which include unit costs and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

6. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments made to reflect benefit features not handled by the AV Calculator are discussed in the attached certification required by 45 CFR Part 156, §156.135.

May 24, 2019

[REDACTED]

Date

## Actuarial Memorandum and Certification

### General Information

#### *Company Identifying Information:*

**Company Legal Name:** Aetna Health Inc.  
**State:** District of Columbia  
**HIOS Issuer ID:** 73987  
**Market:** Small Group  
**Effective Date:** 01/01/2020  
**Rate Filing Tracking Number:** AETN-131944461  
**Policy Form(s):**  
**Form Filing Tracking Number:** AETN-131865435

#### *Company Contact Information:*

**Name:** Joanna Kluza  
**Telephone Number:** (860)273-3099  
**Email Address:** KluzaJ@aetna.com

### 1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

- 1) Provide support for the development of the Part I Unified Rate Review Template;
- 2) Provide support for the assumptions and premiums rate development for the products supported by the policy forms referenced above;
- 3) Request approval of the proposed monthly premium rates; and
- 4) Provide benefit plan designs summaries for the products included in this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.

These rates are for plans issued in District of Columbia beginning January 1, 2020. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be offered outside the public Marketplace in District of Columbia.

### 2. Proposed Rate Increase

Monthly premium rates for Small Group Market products in District of Columbia are being revised for effective dates January 1, 2020 through December 31, 2020.

#### A. Reason for Rate Increase(s):

- Impact of medical claim trend (including changes in provider unit costs and increased utilization of medical cost services) and pharmacy trend;
- Revisions to our assumptions about market-wide population morbidity and the projected population distribution;
- Re-instatement of the Health Insurers Fee after a 1-year hiatus in 2019;
- Revisions to administrative expense projections;
- Modifications in cost sharing to ensure that plans comply with Actuarial Value requirements;
- Updates to our pricing models used to determine the impact of cost sharing designs; and

- Changes in provider networks and contracts.
- Expansion of definition for Small Group eligibility down to one sole proprietor

B. Variation in Rate Changes by Plan/Product:

Rate changes differ by plan for the following reasons:

- Provider cost estimates have been updated, and the change differs by network.
- Modification to cost sharing differs by plan in order to maintain compliance with Actuarial Value and other regulatory requirements.
- Our internal pricing models have been updated to reflect more current information on levels of induced demand associated with different benefit designs. These changes impact our estimates of the relative costs of the plan designs that will be offered.

Exhibit 1 shows the average threshold increases for products covered by this filing.

3. Experience Period Premium and Claims

A. Paid Through Date:

The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2018 through December 31, 2018 and paid through February 2019.

B. Premiums (Net of MLR Rebate) in Experience Period:

Experience period premiums are date-of-service premiums from our actuarial experience databases for non-grandfathered Small Group business in District of Columbia. Our internal projections indicate that no MLR rebate is expected to be paid in 2018 (for 2017 experience) for the Small Group MLR Pool in District of Columbia. As such, no adjustment was made to premiums to account for expected rebates.

C. Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level detail on total allowed and incurred claims but do not include unit cost or utilization metrics. We allocate claims to cost categories and estimate the corresponding unit costs and utilization metrics by using an alternate reporting system that calculates unit cost and utilization metrics by medical cost category but only permits inclusion/exclusion of experience at the market and segment levels. A reconciliation of aggregate data in our actuarial experience databases is performed to ensure that data is consistent with the experience data contained in our enterprise-wide data warehouse.

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects two months of paid claim run-off. The IBNP reserves account for approximately 0.31% of the experience period incurred claims.

4. Benefit Categories

Our internal systems assign claims to several benefit categories. We have mapped these categories to the categories described in the Unified Rate Review Instructions released in April 2019. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, including day-based mental health services. Outpatient Hospital includes outpatient surgical, outpatient mental health, and emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses, including office-based mental health services. Other includes dental, home health care, medical pharmacy expenses, laboratory expenses, and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

## 5. Projection Factors

### A. Changes in the Morbidity of the Population Insured:

The experience period data includes experience for community-rated policies issued to small employers in 2018.

We also considered the expected morbidity of the DC small group ACA population and the likely population that will be covered by Small Group Single Risk Pool policies in 2020 and have adjusted our projections for this morbidity change accordingly. This filing also includes adjustments to projected morbidity assuming the Small Group and Individual Market risk pools are combined for DC. These adjustments are based on a comparison of our Small Group risk scores versus the risk scores of what a merged market would look like using data from CCIO website, as well as the Wakeley study commissioned last year by DC.

### B. Plan Design Changes:

The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for Single Risk Pool products that have essentially identical benefits and coverage.

The change in projected utilization due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.

### C. Changes in Demographics:

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibits 2 and 3 contain detail on the calculations of the impact of demographic mix shifts.

### D. Other Adjustments:

The 'Other' adjustment includes the projected impact of changes in network composition and provider contracts, expected morbidity changes, changes in benefits, and changes in demographics.

E. Trend Factors (Cost/Utilization):

Medical trend factors are based on our Medical Economics Unit's national guidance coupled with local trend and network experience, based on analysis of a continuous normalized population, excluding catastrophic claims. Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

Pharmacy trends are based on national commercial group Rx trend analysis. Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. Pharmacy Trend is expressed in terms of allowed trend less rebates.

Exhibit 8 shows the anticipated annual trend from the experience period to the rating period.

6. Manual Rate Adjustments:

A. Source and Appropriateness of Experience Data Used:

The source data for our manual rate is the experience incurred from January 1, 2018 to December 31, 2018 and paid through February 2019 for issuers 12028 and 86443 in the Virginia Small Group HMO & PPO market. The Small Group market experience is considered an appropriate source for the manual rate due to similarities in covered benefits and market dynamics to the current ACA Small Group market. The similar dynamics include: no individual medical underwriting and rating by gender, limits on age-rating, and caps for rating on the number of dependents, as well as plans benefits and cost-sharing.

B. Adjustments Made to the Data:

The Small Group experience used as the basis for the manual rate was adjusted in a similar manner as the base period experience for changes in population risk morbidity, benefits, and demographic and area normalizations. The data is further adjusted for projected changes in network, provider contract rates, and claims adjudication, in addition to unit cost and utilization trend.

C. Inclusion of Capitation Payments:

No services provided in 2020 will be covered by capitation arrangements. We have adjusted the experience data to incorporate our best-estimate of the impact of moving to fee for service payment approaches.

7. Credibility of Experience

The CMS Medicare full credibility standard is 24,000 member months. Based on our experience, the Medicare population has significantly higher utilization than Commercial populations. Using actuarial judgement, we have assigned 23% credibility to experience data.

8. Risk Adjustment

A. Risk Adjustment – Experience Period

Risk Adjustment transfer is accrued at the issuer and market level based on 2018 Wakely data and our internal projections of how our risk relative to market has changed since that report was issued. The transfer is allocated to the member-level based by applying the HHS risk transfer calculation to each member relative to the imputed market-average, such that members with higher resulting relative transfers scores may have a receivable and members with lower resulting scores may have a payable, regardless of the net market risk transfer result. The resulting member transfers are summed to the HIOS plan level.

B. Risk Adjustment – Projection Period

We started with 2018 Risk Adjustment accruals to determine our current risk transfer relative to the market. The difference between our projected relative risk and the market's is trended for two years.



In addition, the projected risk adjustment transfer includes changes that were outlined in the 2019 Notice of Benefit and Payment Parameters. The 2020 projected market average premium used in the payment transfer formula is also reduced by 14% to remove administrative cost

As a result, we project a risk adjustment receivable, net of the 2020 user fee of \$0.18 PBMPM. The resulting PMPM adjustment, net of risk adjustment user fees, is \$20.01.

#### 9. Non-Benefit Expenses and Profit & Risk

The retention portion of the projected premium is illustrated in Exhibit 5.

Actual general and administrative expenses are based on historical corporate Small Group market expense levels, 2020 projections, and projected changes in expenses, inflation, and membership for 2020 for our National book of Small Group business.

A flat commission per policy per month will be paid to all brokers in DC during open enrollment. Commissions do not vary by plan.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2020, as well as Federal income tax and State Premium taxes. The risk adjustment user fee, as previously mentioned in Section 9, is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

The profit and risk load is consistent with the target used in our original pricing of our 2019 plans. This represents a 3% increase in profit over the final approved filing from last year.

#### 10. Projected Loss Ratio

The expected 2020 MLR for this filing, as defined by PPACA and before any credibility adjustment, is shown in Exhibit 6.

#### 11. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Small Group market in the District of Columbia through Aetna Health Inc.. The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d).

#### 12. Index Rate

The index rates for the experience and projection periods are set equal to the actual and projected allowed claims, respectively, less non-essential health benefits.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are based on our internal company modeling of plan cost-sharing designs, the plan's provider network, delivery system characteristics, and utilization management practices, the impacts (as applicable) of benefits in addition to EHBs catastrophic eligibility criteria, and the distribution and administrative costs applicable to the plan/product. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR 156 §156.80(d)(2).

**Small Group Market Trend Adjustments:** Exhibit 7 illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. Trend factors are developed from annual forward trend and leveraging. A trend factor of 1.00 corresponds to a policy period that begins January 1, 2020.

### 13. Market-Adjusted Index Rate

Exhibit E-1 illustrates the development of the Market Adjusted Index Rate. The market-wide adjustment for Risk Adjustment was discussed, previously. The risk adjustment is displayed on a paid-basis and the exchange user fee is estimated as a PMPM based on the target premium rate on Worksheet 1 of the URRT.

### 14. Plan-Adjusted Index Rates

Exhibit E-2 illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The 2020 Plan Adjusted Index Rates are displayed in Column 7. The following briefly describes how each set of adjustments was determined.

#### A. Actuarial Value, Cost Sharing:

The factors in Column 2 are the product of two separate adjustments:

1. We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. The combination of these two analyses is a projection of the relative paid to allowed ratio which also reflects the impact of out of network coverage.
2. We applied an adjustment for the impact different levels of cost sharing have on the use of medical services, which is based in part on the induced utilization factors used in the Risk Adjustment program. These adjustments are first normalized to result in an aggregate factor of 1.0 when applied to the projected 2020 membership.

#### B. Distribution and Administrative Costs:

Exhibit E-2, Column 3, reflects the adjustment for projected administrative costs, including sales, marketing, any commission expense, profit, and risk. These are discussed above in the 'Non-Benefit Expenses and Profit & Risk' section, excluding the Risk Adjustment User Fee, and the Exchange User Fee, which are reflected in the Market-Adjusted Index Rate. These expense and profit assumptions do not vary by plan.

#### C. Provider Network, Delivery System, and Utilization Management:

The factors in Column 4 reflect the impact of differences in the network size, efficiency, and provider contract terms. We worked with our contracting area and other subject matter experts to review the impact of these differences and the expected impact on allowed claims.

#### D. Benefits in addition to EHBs:

The factors in Column 5 adjust for the impact of benefits in addition to EHBs.

#### E. Catastrophic Plan Eligibility:

This filing does not include catastrophic plans.

#### F. Experience Period Plan Adjusted Index Rates:

Worksheet 2 of the URRT displays the Plan Adjusted Index Rates filed in 2018 for the experience period.

### 15. Calibration

#### A. Age Curve Calibration:

The age factors are based on the HHS Default Standard Age curve. We then project a premium-weighted average age factor for the 2020 membership using the prescribed age curve and the projected age distribution. The calibration factor is the reciprocal of this weighted average factor.

The age that most closely corresponds to the premium weighted overall average age factor is the average age for the single risk pool.

**B. Geographic Factor Calibration:**

Projected area factors are shown in Exhibit 3. Unit cost trend studies were used to evaluate whether there were significant changes to network costs that would require changes from previously filed rating area factors. The geographic calibration factor is the reciprocal of the projected average area factor

**C. Tobacco Factor Calibration**

We are not applying a tobacco factor in our rating.

**16. Consumer-Adjusted Premium Rate Development**

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three child dependents under age 21, only the three oldest child dependents will be considered in determining the family's premium. Additional child dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:

Calibrated Plan Adjusted Index Rate \* Age Factor \* Area Factor \* Trend Factor

The resulting rate is rounded to the nearest cent, and rates are then summed for all billable family members.

An example of a contract's premium determined by the member build-up calculation for a family of six, with more than three dependents under age 21, is shown in Exhibit 9.

**17. Composite Premiums**

Small employers will be able to elect to have rates set using a composite approach as permitted by DC.

**18. AV Metal Values**

The AV Metal Values on Worksheet 2 were based on the AV 2020 Calculator. As applicable, entries were modified to reflect the plan appropriately and/or adjustments were made for plan design features that could not be entered in the calculator per 45 CFR Part 156, §156.135. The accompanying certification discusses how the benefits were modified to fit the parameters and the development of any adjustments. The AV screen shots provide detail on the modified entries and adjustments to AV, as applicable.

**19. AV Pricing Values**

The AV Pricing Values are calculated as the ratio of the Plan Adjusted Index Rate to the Market Adjusted Index Rate. The adjustments reflected in the AV Pricing Values are discussed in Section 15. AV Pricing Values do not differ based on morbidity differences or benefit selection anticipated within the Single Risk Pool.

**20. Membership Projections**

Exhibit A summarizes the membership distribution by plan. Membership projections on Worksheet 2 are based on historical experience, enrollment in ACA-compliant plans through January 2019, and our expectations for future sales as additional members move to these plans from grandfathered and transitional plans.

**Terminated Plans and Products**

Exhibit 10 provides a plan and product crosswalk from 2018 to 2020. The crosswalk includes the list of products that have experience in the single risk pool experience period, and products that were made available in 2019 and 2020.

Consistent with the URRT instructions, experience for non-single risk pool terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

#### 21. Plan Type

All plans are consistent with the plan type indicated on Worksheet 2.

#### 22. Benefit Design

This filing includes one Bronze, three Silver, and four Gold plans.

Please refer to the corresponding policy forms for detailed benefit language. Exhibit A-2 provides the screenshots from the AV Calculator. All benefit and cost sharing parameters comply with DC benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

#### 23. Marketing

Plans will be available outside of the public Marketplace. These plans may be marketed in a variety of means, including HHS Planfinder and our own website. In addition, members of our 2018 plans will be mailed a discontinuance or renewal letter, in accordance with CMS guidelines. Marketing and distribution approaches may change from time to time at management's discretion.

#### 24. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations.

#### 25. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

#### 26. Company Financial Condition

As of December 31, 2018, the capital and surplus held by Aetna Health Inc. was approximately \$489.5 million. This amount is disclosed in page 3, line 33 of the Company's statutory financial statement dated December 31, 2018. The Company issues insurance nationwide for multiple lines of business including, large group medical, Small Group medical, and various non-medical products.

#### Reliance

While I have reviewed the reasonableness of the assumptions and data in support of both the preparation of the Part I Unified Rate Review Template and the rate development applicable to the products discussed in this filing, I relied on the expertise of other Aetna employees, along with work products produced at their direction, for the following items:

- Experience Period MLR Rebates
- Risk Adjustment Transfer
- Actuarial Value, Modifications, and Benefit Relativities
- Supplemental EHB Pricing
- Population Risk Morbidity
- Medical Cost and Utilization Trend
- Rx Cost and Utilization Trend

- Components of Retention/Administrative Fees
- Value of Network Arrangements
- MH Net Trend
- Experience Period Data – Small Group

### Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated marketplaces, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, Joanna Kluza, am an Associate of the Society of Actuaries, a member of the American Academy of Actuaries, and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the District of Columbia, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:
  - a. ASOP No. 5, Incurred Health and Disability Claims
  - b. ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health
  - c. ASOP No. 12, Risk Classification
  - d. ASOP No. 23, Data Quality
  - e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
  - f. ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
  - g. ASOP No. 41, Actuarial Communications
  - h. ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act
  - i.
2. The Projected Index Rate is:
  - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1) and 147.102),
  - b. Developed in compliance with the applicable Actuarial Standards of Practice,
  - c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
  - d. Neither excessive, deficient, nor unfairly discriminatory.
3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

5. The geographic rating factors reflect only differences in the costs of delivery (which include unit costs and provider practice pattern differences) and do not include differences for population morbidity by geographic area.
6. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments made to reflect benefit features not handled by the AV Calculator are discussed in the attached certification required by 45 CFR Part 156, §156.135.



---

Joanna Kluza, ASA, MAAA  
Aetna Health Inc.

May 24, 2019

Date

## Actuarial Memorandum and Certification

### General Information

*Company Identifying Information:*

**Company Legal Name:** Aetna Health Inc.  
**State:** District of Columbia  
**HIOS Issuer ID:** 73987  
**Market:** Small Group  
**Effective Date:** 01/01/2020  
**Rate Filing Tracking Number:** AETN-131944461  
**Policy Form(s):**  
**Form Filing Tracking Number:** AETN-131865435

*Company Contact Information:*

**Name:**  
**Telephone Number:**  
**Email Address:**



### 1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

- 1) Provide support for the development of the Part I Unified Rate Review Template;
- 2) Provide support for the assumptions and premiums rate development for the products supported by the policy forms referenced above;
- 3) Request approval of the proposed monthly premium rates; and
- 4) Provide benefit plan designs summaries for the products included in this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation. These rates are for plans issued in District of Columbia beginning January 1, 2020. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be offered outside the public Marketplace in District of Columbia.

### 2. Proposed Rate Increase

Monthly premium rates for Small Group Market products in District of Columbia are being revised for effective dates January 1, 2020 through December 31, 2020.

**A. Reason for Rate Increase(s):**

- Impact of medical claim trend (including changes in provider unit costs and increased utilization of medical cost services) and pharmacy trend;
- Revisions to our assumptions about market-wide population morbidity and the projected population distribution;
- Re-instatement of the Health Insurers Fee after a 1-year hiatus in 2019;
- Revisions to administrative expense projections;
- Modifications in cost sharing to ensure that plans comply with Actuarial Value requirements;
- Updates to our pricing models used to determine the impact of cost sharing designs; and

- Changes in provider networks and contracts.
- Expansion of definition for Small Group eligibility down to one sole proprietor

B. Variation in Rate Changes by Plan/Product:

Rate changes differ by plan for the following reasons:

- Provider cost estimates have been updated, and the change differs by network.
- Modification to cost sharing differs by plan in order to maintain compliance with Actuarial Value and other regulatory requirements.
- Our internal pricing models have been updated to reflect more current information on levels of induced demand associated with different benefit designs. These changes impact our estimates of the relative costs of the plan designs that will be offered.

Exhibit 1 shows the average threshold increases for products covered by this filing.

3. Experience Period Premium and Claims

A. Paid Through Date:

The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2018 through December 31, 2018 and paid through February 2019.

B. Premiums (Net of MLR Rebate) in Experience Period:

Experience period premiums are date-of-service premiums from our actuarial experience databases for non-grandfathered Small Group business in District of Columbia. [REDACTED]

C. Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level detail on total allowed and incurred claims but do not include unit cost or utilization metrics. We allocate claims to cost categories and estimate the corresponding unit costs and utilization metrics by using an alternate reporting system that calculates unit cost and utilization metrics by medical cost category but only permits inclusion/exclusion of experience at the market and segment levels. A reconciliation of aggregate data in our actuarial experience databases is performed to ensure that data is consistent with the experience data contained in our enterprise-wide data warehouse.

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects two months of paid claim run-off. [REDACTED]

4. Benefit Categories



Our internal systems assign claims to several benefit categories. We have mapped these categories to the categories described in the Unified Rate Review Instructions released in April 2019. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, including day-based mental health services. Outpatient Hospital includes outpatient surgical, outpatient mental health, and emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses, including office-based mental health services. Other includes dental, home health care, medical pharmacy expenses, laboratory expenses, and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

## 5. Projection Factors

### A. Changes in the Morbidity of the Population Insured:

The experience period data includes experience for community-rated policies issued to small employers in 2018.

We also considered the expected morbidity of the DC small group ACA population and the likely population that will be covered by Small Group Single Risk Pool policies in 2020 and have adjusted our projections for this morbidity change accordingly. This filing also includes adjustments to projected morbidity assuming the Small Group and Individual Market risk pools are combined for DC. These adjustments are based on a comparison of our Small Group risk scores versus the risk scores of what a merged market would look like using data from CCIO website, as well as the Wakeley study commissioned last year by DC.

### B. Plan Design Changes:

The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for Single Risk Pool products that have essentially identical benefits and coverage.

The change in projected utilization due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.

### C. Changes in Demographics:

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibits 2 and 3 contain detail on the calculations of the impact of demographic mix shifts.

### D. Other Adjustments:

The 'Other' adjustment includes the projected impact of changes in network composition and provider contracts, expected morbidity changes, changes in benefits, and changes in demographics.

E. Trend Factors (Cost/Utilization):

[REDACTED]

[REDACTED]

[REDACTED]

6. Manual Rate Adjustments:

A. Source and Appropriateness of Experience Data Used:

[REDACTED]

B. Adjustments Made to the Data:

[REDACTED]

C. Inclusion of Capitation Payments:

[REDACTED]

7. Credibility of Experience

[REDACTED]

8. Risk Adjustment

A. Risk Adjustment – Experience Period

[REDACTED]

B. Risk Adjustment – Projection Period

[REDACTED]

[REDACTED]

[REDACTED]

#### 9. Non-Benefit Expenses and Profit & Risk

[REDACTED]

Actual general and administrative expenses are based on historical corporate Small Group market expense levels, 2020 projections, and projected changes in expenses, inflation, and membership for 2020 for our National book of Small Group business.

A flat commission per policy per month will be paid to all brokers in DC during open enrollment. Commissions do not vary by plan.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2020, as well as Federal income tax and State Premium taxes. The risk adjustment user fee, as previously mentioned in Section 9, is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

[REDACTED]

#### 10. Projected Loss Ratio

[REDACTED]

#### 11. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Small Group market in the District of Columbia through Aetna Health Inc.. The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d).

#### 12. Index Rate

The index rates for the experience and projection periods are set equal to the actual and projected allowed claims, respectively, less non-essential health benefits.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are based on our internal company modeling of plan cost-sharing designs, the plan's provider network, delivery system characteristics, and utilization management practices, the impacts (as applicable) of benefits in addition to EHBs catastrophic eligibility criteria, and the distribution and administrative costs applicable to the plan/product. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR 156 §156.80(d)(2).

#### **Small Group Market Trend Adjustments:**

[REDACTED]

13. Market-Adjusted Index Rate

[REDACTED]

14. Plan-Adjusted Index Rates

[REDACTED]

A. Actuarial Value, Cost Sharing:

The factors in Column 2 are the product of two separate adjustments:

[REDACTED]

B. Distribution and Administrative Costs:

[REDACTED]

C. Provider Network, Delivery System, and Utilization Management:

[REDACTED]

D. Benefits in addition to EHBs:

[REDACTED]

E. Catastrophic Plan Eligibility:

This filing does not include catastrophic plans.

F. Experience Period Plan Adjusted Index Rates:

Worksheet 2 of the URRT displays the Plan Adjusted Index Rates filed in 2018 for the experience period.

15. Calibration

A. Age Curve Calibration:

[REDACTED]

B. Geographic Factor Calibration:

C. Tobacco Factor Calibration

We are not applying a tobacco factor in our rating.

16. Consumer-Adjusted Premium Rate Development

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three child dependents under age 21, only the three oldest child dependents will be considered in determining the family's premium. Additional child dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:

Calibrated Plan Adjusted Index Rate \* Age Factor \* Area Factor \* Trend Factor

The resulting rate is rounded to the nearest cent, and rates are then summed for all billable family members.

17. Composite Premiums

Small employers will be able to elect to have rates set using a composite approach as permitted by DC.

18. AV Metal Values

The AV Metal Values on Worksheet 2 were based on the AV 2020 Calculator. As applicable, entries were modified to reflect the plan appropriately and/or adjustments were made for plan design features that could not be entered in the calculator per 45 CFR Part 156, §156.135. The accompanying certification discusses how the benefits were modified to fit the parameters and the development of any adjustments. The AV screen shots provide detail on the modified entries and adjustments to AV, as applicable.

19. AV Pricing Values

The AV Pricing Values are calculated as the ratio of the Plan Adjusted Index Rate to the Market Adjusted Index Rate. The adjustments reflected in the AV Pricing Values are discussed in Section 15. AV Pricing Values do not differ based on morbidity differences or benefit selection anticipated within the Single Risk Pool.

20. Membership Projections

Terminated Plans and Products

Exhibit 10 provides a plan and product crosswalk from 2018 to 2020. The crosswalk includes the list of products that have experience in the single risk pool experience period, and products that were made available in 2019 and 2020.

Consistent with the URRT instructions, experience for non-single risk pool terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

#### 21. Plan Type

All plans are consistent with the plan type indicated on Worksheet 2.

#### 22. Benefit Design

This filing includes one Bronze, three Silver, and four Gold plans.

Please refer to the corresponding policy forms for detailed benefit language. Exhibit A-2 provides the screenshots from the AV Calculator. All benefit and cost sharing parameters comply with DC benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

#### 23. Marketing

Plans will be available outside of the public Marketplace. These plans may be marketed in a variety of means, including HHS Planfinder and our own website. In addition, members of our 2018 plans will be mailed a discontinuance or renewal letter, in accordance with CMS guidelines. Marketing and distribution approaches may change from time to time at management's discretion.

#### 24. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations.

#### 25. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

#### 26. Company Financial Condition

[REDACTED]

#### Reliance

While I have reviewed the reasonableness of the assumptions and data in support of both the preparation of the Part I Unified Rate Review Template and the rate development applicable to the products discussed in this filing, I relied on the expertise of other Aetna employees, along with work products produced at their direction, for the following items:

[REDACTED]

Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated marketplaces, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, [REDACTED], am an [REDACTED], and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the District of Columbia, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:
  - a. ASOP No. 5, Incurred Health and Disability Claims
  - b. ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health
  - c. ASOP No. 12, Risk Classification
  - d. ASOP No. 23, Data Quality
  - e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
  - f. ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
  - g. ASOP No. 41, Actuarial Communications
  - h. ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act
  - i.
2. The Projected Index Rate is:
  - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1) and 147.102),
  - b. Developed in compliance with the applicable Actuarial Standards of Practice,
  - c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
  - d. Neither excessive, deficient, nor unfairly discriminatory.
3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

5. The geographic rating factors reflect only differences in the costs of delivery (which include unit costs and provider practice pattern differences) and do not include differences for population morbidity by geographic area.
6. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments made to reflect benefit features not handled by the AV Calculator are discussed in the attached certification required by 45 CFR Part 156, §156.135.

May 24, 2019

Date

\_\_\_\_\_

\_\_\_\_\_



**Aetna Health Inc.  
D.C. Small Group  
HMO Products**

**Summary**

Aetna Health Inc. has filed 2020 premium rates for small group plans in the District of Columbia.

**Who is affected?**

Policies that renew in 2020 in the following products will be affected:

<u>Product Name</u>	<u># Current Members</u>	<u>Range of Increases</u>
Aetna Health Inc	850	4.6% to 30.8%, 16.1% Average

2020 Premium rates for members in the above products will increase by 4.6% to 30.8% in plans listed for Aetna Health Maintenance Organization. Increases are determined by the member's plan and rating area in which they are located.

**Why We Need to Increase Premiums**

In 2018, Aetna's financial results were worse than the level required for long-term stability in the Small Group market.

Medical costs are going up and we are changing our rates to reflect this increase. We expect medical costs to go up 11.2%. Medical costs go up mainly for two reasons – providers raise their prices and members get more medical care.

For Small Employers in the District of Columbia, some examples of increasing medical costs we have experienced in the last 12 months include:

- The cost for an inpatient hospital admission has increased 5.9%
- The cost for pharmacy prescriptions have gone up 11.7%
- Use for physician service has increased 6.3%

**What Else Affects Our Request to Increase Premiums**

Our estimate of average population health and the expected risk adjustment transfers for Affordable Care Act (ACA) products have changed to reflect new data on market average premiums and population health. Small groups purchasing insurance in the market place are sicker than we initially anticipated. Population risk is also affected by the movement of business between the ACA market and other options as well as among other carriers in the marketplace. These changes are expected to increase costs by 2.5%.

**Will Premiums for All Individuals Increase 16.1%?**

No, Increases differ by plan. Some premiums will increase by less than average or even go down. Others will increase by more than the average.

The exact rate change will depend on what benefit plan the individual chooses, when the member's group contract renews, the age and family size and age for enrolling employees, and employer contributions.

### **How does this request align to Minimum Loss Ratio Requirements (MLR)?**

Non-claim costs are also going up. The Federal Health Insurers Fee has been reinstated after a reprieve in 2017. Some costs, such as operating our IT systems, complying with reporting requirements, and managing our business remain fixed, and are now being spread across fewer members, resulting in higher administrative costs. Aetna will only charge members for the portion of administrative costs that enable plans to still meet the 80% Minimum Loss Ratio requirement.

These rates are expected to produce an MLR equal to or above the 80% requirement for small group business. Under the ACA, at least 80% of the premiums collected by health plans are expected to pay for medical care and activities that improve health care quality for members. If the actual MLR turns out to be less than 80%, rebates will be issued to members in accordance with the law.

Aetna makes significant investments that benefit our members that the government does not allow us to use in this calculation. These investments include customer service, health quality activities like disease management programs, and the development of new information technologies.

### **What is Aetna doing to keep premiums affordable?**

Aetna is taking a number of steps to keep our products as affordable as possible and to address the underlying cost of health care. These actions include:

- Developing new agreements, arrangements, and partnerships with health care providers that base provider compensation on the quality of care and not the quantity of services.
- Creating medical management programs that address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.
- Working to reduce the ability of out-of-network providers to collect unreasonably excessive payments for services they provide.

Aetna is dedicated to increasing transparency within the health care system and helping members best utilize the plans that they have. Members can access Aetna Navigator, a secure member website, which allows them to research their specific plan benefits, health care providers in a given area, and in some locations, the cost of certain health care services. Additionally, Aetna's DocFind directory helps members locate in-network doctors and hospitals to save money on their care. The Aetna Navigator streamlined mobile app is also available to allow members to take their care on the go.

Also, Aetna's Plan for Your Health website aims to educate all consumers on how to take advantage of their health care benefits.

**Aetna Health Inc.  
D.C. Small Group  
HMO Products**

**Summary**

Aetna Health Inc. has filed 2020 premium rates for small group plans in the District of Columbia.

**Who is affected?**

Policies that renew in 2020 in the following products will be affected:

<u>Product Name</u>	<u># Current Members</u>	<u>Range of Increases</u>
Aetna Health Inc	850	7.5% to 34.4%, 19.3% Average

2020 Premium rates for members in the above products will increase by 7.5% to 34.4% in plans listed for Aetna Health Maintenance Organization. Increases are determined by the member's plan and rating area in which they are located.

**Why We Need to Increase Premiums**

In 2018, Aetna's financial results were worse than the level required for long-term stability in the Small Group market.

Medical costs are going up and we are changing our rates to reflect this increase. We expect medical costs to go up 11.2%. Medical costs go up mainly for two reasons – providers raise their prices and members get more medical care.

For Small Employers in the District of Columbia, some examples of increasing medical costs we have experienced in the last 12 months include:

- The cost for an inpatient hospital admission has increased 5.9%
- The cost for pharmacy prescriptions have gone up 11.7%
- Use for physician service has increased 6.3%

**What Else Affects Our Request to Increase Premiums**

Our estimate of average population health and the expected risk adjustment transfers for Affordable Care Act (ACA) products have changed to reflect new data on market average premiums and population health, including the combining of the Small Group and Individual markets. Small groups purchasing insurance in the market place are sicker than we initially anticipated. Population risk is also affected by the movement of business between the ACA market and other options as well as among other carriers in the marketplace. These changes are expected to increase costs by 5.5%.

**Will Premiums for All Individuals Increase 19.3%?**

No, Increases differ by plan. Some premiums will increase by less than average or even go down. Others will increase by more than the average.

The exact rate change will depend on what benefit plan the individual chooses, when the member's group contract renews, the age and family size and age for enrolling employees, and employer contributions.

### **How does this request align to Minimum Loss Ratio Requirements (MLR)?**

Non-claim costs are also going up. The Federal Health Insurers Fee has been reinstated after a reprieve in 2017. Some costs, such as operating our IT systems, complying with reporting requirements, and managing our business remain fixed, and are now being spread across fewer members, resulting in higher administrative costs. Aetna will only charge members for the portion of administrative costs that enable plans to still meet the 80% Minimum Loss Ratio requirement.

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- Creating medical management programs that address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.
- Working to reduce the ability of out-of-network providers to collect unreasonably excessive payments for services they provide.

Aetna is dedicated to increasing transparency within the health care system and helping members best utilize the plans that they have. Members can access Aetna Navigator, a secure member website, which allows them to research their specific plan benefits, health care providers in a given area, and in some locations, the cost of certain health care services. Additionally, Aetna's DocFind directory helps members locate in-network doctors and hospitals to save money on their care. The Aetna Navigator streamlined mobile app is also available to allow members to take their care on the go.

Also, Aetna's Plan for Your Health website aims to educate all consumers on how to take advantage of their health care benefits.



980 Jolly Road  
Mail Code U12S  
Blue Bell, PA 19422  
(215)-775-3837  
Fax: (215)-775-6441

May 17, 2019

Mr. Efren Tanheco  
Supervising Actuary  
District of Columbia Department of Insurance & Securities Regulation  
810 First Street NE, 6<sup>th</sup> Floor  
Washington, DC 20002

Subject: Aetna Health, Inc. - NAIC Number 95109  
Small Group Premium Rate Filing – DC On Exchange  
Effective dates January 1, 2020 – December 31, 2020

Dear Mr. Tanheco:

I am writing to request approval of the attached Rate Filing for plans offered to Small Groups by Aetna Health, Inc. sold on the DC Exchange. This filing is for effective dates January 1, 2020 – December 31, 2020. This filing contains the benefit plans and rating methodology. The average rate revision proposed is an increase of 16.1%.

The requested rates have been developed incorporating consideration of the market changes and rating requirements taking effect in the Small Group Market and conforms to the benefit plan provisions required by the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010. Additionally, these health benefit plans conform to each respective tier of coverage, defined as Bronze, Silver, and Gold.

This filing is for Aetna's Small Group HMO Medical Expense coverage.

The following supporting documentation is also included:

- 1) An Actuarial Certification
- 2) An Actuarial Memorandum including supporting exhibits and documentation

The forms filing has been submitted under separate cover and the SERFF Filing ID # is AETN-131865435.

The purpose of this rate filing is to comply with regulatory rate filing requirements. This filing is not intended to be used for other purposes. If you need additional information, please contact me by telephone at (860) 273-8566, or via e-mail at MurayiR@aetna.com

Sincerely,

A handwritten signature in black ink, appearing to read "Regis Murayi". The signature is fluid and cursive, with a prominent initial "R" and a trailing flourish.

Regis Murayi

**Certificate Form Names and Numbers**

<i>Form Name</i>	<i>Form Number</i>
HI DC SG HHIXCOC V004	HI SG HCOC-2020 04-HIX
HI DC HGrpAg V003	HI SG HGrpAg 03

**Schedule Form Names and Numbers**

<i>Form Name</i>	<i>Form Number</i>
HI DC SG-HIXSOB-14042181 V004	HI SG-SOB-HMO-14042181 04-HIX
HI DC SG-HIXSOB-14042176 V004	HI SG-SOB-HMO-14042176 04-HIX
HI DC SG-HIXSOB-14042177 V004	HI SG-SOB-HMO-14042177 04-HIX
HI DC SG-HIXSOB-14042182 V004	HI SG-SOB-HMO-14042182 04-HIX
HI DC SG-HIXSOB-14042179 V004	HI SG-SOB-HMO-14042179 04-HIX
HI DC SG-HIXSOB-14042188 V004	HI SG-SOB-HMO-14042188 04-HIX
HI DC SG-HIXSOB-14042180 V004	HI SG-SOB-HMO-14042180 04-HIX
HI DC SG-HIXSOB-14042178 V004	HI SG-SOB-HMO-14042178 04-HIX



980 Jolly Road  
Mail Code U12S  
Blue Bell, PA 19422  
(215)-775-3837  
Fax: (215)-775-6441

May 17, 2019

Mr. Efren Tanheco  
Supervising Actuary  
District of Columbia Department of Insurance & Securities Regulation  
810 First Street NE, 6<sup>th</sup> Floor  
Washington, DC 20002

Subject: Aetna Health, Inc. - NAIC Number 95109  
Small Group Premium Rate Filing – DC On Exchange  
Effective dates January 1, 2020 – December 31, 2020

Dear Mr. Tanheco:

I am writing to request approval of the attached Rate Filing for plans offered to Small Groups by Aetna Health, Inc. sold on the DC Exchange. This filing is for effective dates January 1, 2020 – December 31, 2020. This filing contains the benefit plans and rating methodology. The average rate revision proposed is an increase of 19.3%.

The requested rates have been developed incorporating consideration of the market changes and rating requirements taking effect in the Small Group Market and conforms to the benefit plan provisions required by the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010. Additionally, these health benefit plans conform to each respective tier of coverage, defined as Bronze, Silver, and Gold.

This filing is for Aetna's Small Group HMO Medical Expense coverage.

The following supporting documentation is also included:

- 1) An Actuarial Certification
- 2) An Actuarial Memorandum including supporting exhibits and documentation

The forms filing has been submitted under separate cover and the SERFF Filing ID # is AETN-131865435.

The purpose of this rate filing is to comply with regulatory rate filing requirements. This filing is not intended to be used for other purposes. If you need additional information, please contact me by telephone at (860) 273-8566, or via e-mail at MurayiR@aetna.com

Sincerely,

A handwritten signature in black ink, appearing to read "Regis Murayi". The signature is fluid and cursive, with a long horizontal stroke at the end.

Regis Murayi

**Certificate Form Names and Numbers**

<i>Form Name</i>	<i>Form Number</i>
HI DC SG HHIXCOC V004	HI SG HCOC-2020 04-HIX
HI DC HGrpAg V003	HI SG HGrpAg 03

**Schedule Form Names and Numbers**

<i>Form Name</i>	<i>Form Number</i>
HI DC SG-HIXSOB-14042181 V004	HI SG-SOB-HMO-14042181 04-HIX
HI DC SG-HIXSOB-14042176 V004	HI SG-SOB-HMO-14042176 04-HIX
HI DC SG-HIXSOB-14042177 V004	HI SG-SOB-HMO-14042177 04-HIX
HI DC SG-HIXSOB-14042182 V004	HI SG-SOB-HMO-14042182 04-HIX
HI DC SG-HIXSOB-14042179 V004	HI SG-SOB-HMO-14042179 04-HIX
HI DC SG-HIXSOB-14042188 V004	HI SG-SOB-HMO-14042188 04-HIX
HI DC SG-HIXSOB-14042180 V004	HI SG-SOB-HMO-14042180 04-HIX
HI DC SG-HIXSOB-14042178 V004	HI SG-SOB-HMO-14042178 04-HIX



Unified Rate Review v5.0

Company Legal Name:

Aetna Health Inc. (a PA corp.)

HIOS Issuer ID:

73987

Effective Date of Rate Change(s):

01/01/2020

State:

DC

Market:

Small Group

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.

To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.

To validate, select the Validate button or Ctrl + Shift + I.

To finalize, select the Finalize button or Ctrl + Shift + F.

Market Level Calculations (Same for all Plans)

Section I: Experience Period Data

Experience Period:

01/01/2018

to

12/31/2018

Total

PMPM

Allowed Claims

\$1,860,368.85

\$682.95

Reinsurance

\$0.00

\$0.00

Incurred Claims in Experience Period

\$1,659,963.79

\$499.38

Risk Adjustment

\$344,979.55

\$126.64

Experience Period Premium

\$1,344,973.73

\$493.75

Experience Period Member Months

2,724

Section II: Projections

Benefit Category	Experience Period Index	Year 1 Trend			Year 2 Trend			Trended EHB Allowed Claims
		Rate PMPM	Cost	Utilization	Cost	Utilization	PMPM	
Inpatient Hospital	2077.56	1.099	1.028	1.099	1.039	\$245.39		
Outpatient Hospital	564.54	1.041	1.068	1.041	1.069	\$79.78		
Professional	\$117.60	1.015	1.063	1.015	1.063	\$136.30		
Other Medical	\$153.85	1.061	1.068	1.041	1.068	\$188.30		
Capitation	\$0.00	1.000	1.000	1.000	1.000	\$0.00		
Prescription Drug	\$459.45	1.117	1.033	1.117	1.033	\$486.86		
Total	\$682.95					\$638.53		
Morbidity Adjustment					1.025			
Demographic Shift					0.939			
Plan Design Changes					1.000			
Other					0.910			
Adjusted Trended EHB Allowed Claims PMPM for	01/01/2020				\$723.84			
Manual EHB Allowed Claims PMPM					\$499.31			
Applied Credibility %					23.00%			
Projected Period Totals								
Projected Index Rate for	01/01/2020			\$556.64		\$27,612.00		
Reinsurance				\$0.00		\$0.00		
Risk Adjustment Payment/Charge				\$24.03		\$1,200.50		
Exchange User Fees				\$0.00		\$0.00		
Market Adjusted Index Rate				\$526.63		\$26,391.50		
Projected Member Months						50		

Information Not Releasable to the Public Unless Authorized by Law:

This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

1 of 3



A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE
204																														

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.  
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.  
To validate, select the Validate button or Ctrl + Shift + I.  
To finalize, select the Finalize button or Ctrl + Shift + F.

State: DC  
Market: Small Group

## Field # Section I: General Product and Plan Information

1.1	Product Name	HealthNetworkOnlyOpenAccess								
1.2	Product ID	73987PC004								
1.3	Plan Name	Aetna Gold HNOnly 70% \$25/40 E	Aetna Gold HNOnly 50 90% \$25/40 E	Aetna Silver HNOnly 4800 80% \$25/40 E	Aetna Silver HNOnly 3650 \$15/50 E	Aetna Silver HNOnly 3000 \$15/50 E	Aetna Bronze HNOnly 6000 80% E	Aetna Gold HNOnly 1500 90% E	Aetna Silver HNOnly 2800 90% E	Aetna Silver HNOnly 2800 90% E
1.4	Plan ID (Standard Component ID)	73987C00400017	73987C00400021	73987C00400057	73987C00400046	73987C00400029	73987C00400056	73987C00400058	73987C00400058	73987C00400058
1.5	Metal	Gold	Gold	Silver	Gold	Silver	Bronze	Gold	Gold	Gold
1.6	At Market Value	0.81%	0.79%	0.72%	0.79%	0.73%	0.61%	0.79%	0.71%	0.71%
1.7	Plan Category	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing
1.8	Plan Type	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
1.9	Exchange Plan?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
1.10	Effective Date of Proposed Rates	01/01/2020	01/01/2020	01/01/2020	01/01/2020	01/01/2020	01/01/2020	01/01/2020	01/01/2020	01/01/2020
1.11	Cumulative Rate Change % (over 12 mos prior)	24.63%	16.11%	27.55%	7.36%	21.71%	30.80%	4.63%	0.00%	0.00%
1.12	Product Rate Increase %				16.13%					
1.13	Submission Level Rate Increase %				16.13%					

## Section II: Experience Period and Current Plan Level Information

		Total	73987C0040001	73987C0040021	73987C0040031	73987C0040046	73987C0040059	73987C0040068	73987C0040098	73987C0040098	73987C0040098
\$1,860,369	2.1 Allowed Claims	\$1,860,369	\$1,860,369	\$1,406,731	\$511	\$28,656	\$44,928	\$52,853	\$0	\$0	\$0
\$0	2.2 Reinsurance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$0	2.4 Member Cost Sharing	\$200,405	\$29,698	\$95,058	\$432	\$13,230	\$23,189	\$38,138	\$0	\$0	\$0
\$0	2.5 Cost Sharing Reduction	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$1,659,964	2.6 Incurred Claims	\$1,659,964	\$297,361	\$1,311,073	\$79	\$15,366	\$21,369	\$14,716	\$0	\$0	\$0
\$344,978	2.7 Risk Adjustment Transfer Amount	\$344,978	\$51,976	\$464,568	\$-613	\$-69,838	\$-52,012	\$-124,131	\$0	\$0	\$0
\$1,314,974	2.8 Premium	\$1,314,974	\$285,780	\$627,176	\$1,043	\$121,077	\$102,760	\$207,165	\$0	\$0	\$0
2,724	2.9 Experience Period Member Months	2,724	985	1,151	3	243	195	3	967	0	0
\$0	2.10 Current Enrollment	850	151	131	33	13	83	180	151	\$0	\$0
\$0	2.11 Current Premium PMPM	\$387.71	\$403.17	\$436.96	\$321.79	\$435.67	\$356.56	\$255.71	\$453.59	\$0	\$0
\$0	2.12 Loss Ratio	98.23%	128.28%	103.01%	18.42%	30.00%	42.08%	17.74%	RDV(0)	RDV(0)	RDV(0)
	<b>Per Member Per Month</b>										
\$1,134,974	2.13 Allowed Claims	\$682.95	\$559.08	\$1,243.79	\$170.41	\$117.92	\$228.50	\$93.22	RDV(0)	RDV(0)	RDV(0)
\$0	2.14 Reinsurance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	RDV(0)	RDV(0)	RDV(0)
\$0	2.15 Member Cost Sharing	\$73.57	\$50.77	\$84.58	\$144.00	\$54.69	\$118.92	\$67.26	RDV(0)	RDV(0)	RDV(0)
\$0	2.16 Cost Sharing Reduction	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	RDV(0)	RDV(0)	RDV(0)
\$1,134,974	2.17 Incurred Claims	\$609.18	\$468.11	\$1,150.27	\$61.41	\$19.58	\$109.58	\$25.95	RDV(0)	RDV(0)	RDV(0)
\$0	2.18 Risk Adjustment Transfer Amount	\$126.64	\$-92.27	\$570.79	\$-204.32	\$-287.48	\$-266.73	\$-218.93	RDV(0)	RDV(0)	RDV(0)
\$0	2.19 Premium	\$493.75	\$488.51	\$554.53	\$347.75	\$498.26	\$527.13	\$365.26	RDV(0)	RDV(0)	RDV(0)

3.1 Plan ID (Standard Component ID)	73987DC0040017	73987DC0040021	73987DC0040057	73987DC0040046	73987DC0040029	73987DC0040056	73987DC0040058	73987DC0040005
3.2 Plan ID (Standard Component ID)	73987DC0040005							

[illegible]

4.1 Plan ID (Standard Component ID)	Total	73987DC0040017	73987DC0040021	73987DC0040057	73987DC0040046	73987DC0040029	73987DC0040056	73987DC0040058	73987DC004005
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4.1	Allowed Claims	\$2,534	\$5,121	\$5,172	\$516	\$5,192	\$543	\$5,489	\$5,654	\$5,654
4.2	Reinsurance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4.3	Member Cost Sharing	\$4,541	\$504	\$511	\$97	\$902	\$303	\$3,689	\$684	\$99
4.5	Cost Sharing Reduction	\$6,642	\$926	\$1,046	\$145	\$1,062	\$157	\$2,098	\$1,003	\$15
4.6	Incurred Claims	\$16,351	\$3,691	\$3,616	\$274	\$3,228	\$274	\$1,658	\$3,068	\$274
4.7	Risk Adjustment Transfer Amount	\$1,002	\$179	\$179	\$20	\$180	\$20	\$225	\$180	\$2
4.8	Premium	\$28,053	\$5,633	\$5,688	\$511	\$5,234	\$541	\$4,383	\$5,321	\$541
4.9	Projected Member Months	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4.10	Loss Ratio	\$6.27%	63.51%	61.93%	51.64%	59.63%	51.10%	34.48%	60.14%	51.36%
<b>Per Member Per Month</b>										
4.11	Allowed Claims	\$550.68	\$568.97	\$574.70	\$516.44	\$575.88	\$546.26	\$489.89	\$561.62	\$543.1
4.12	Reinsurance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
4.13	Member Cost Sharing	\$90.82	\$55.97	\$56.73	\$97.43	\$100.21	\$103.20	\$148.41	\$77.08	\$98.1
4.14	Cost Sharing Reduction	\$132.85	\$102.89	\$116.24	\$144.61	\$117.98	\$156.55	\$190.76	\$116.98	\$155.3
4.15	Incurred Claims	\$332.02	\$337.45	\$340.72	\$278.45	\$338.68	\$338.51	\$150.72	\$338.77	\$338.7
4.16	Risk Adjustment Transfer Amount	\$20.05	\$11.87	\$11.85	\$20.19	\$19.99	\$20.11	\$20.45	\$19.97	\$20.1
4.17	Premium	\$661.07	\$625.90	\$631.96	\$511.23	\$581.57	\$546.56	\$416.64	\$591.18	\$581.8

Rating Area Data Collection

Specify the total number of Rating  
Select only the Rating Areas you are  
To validate, select the Validate button  
To finalize, select the Finalize button

Rating Area	Rating Factor
Rating Area 1	1.0000

*Areas in your State by selecting the Create Rating Areas button or Ctrl + Shift + R.  
re offering plans within and add a factor for each area.  
tton or Ctrl + Shift + I.  
on or Ctrl + Shift + F.*

Unified Rate Review v5.0

Company Legal Name:  
HIOS Issuer ID:  
Effective Date of Rate Change(s):

Aetna Health Inc. (a PA corp.)  
73987  
01/01/2020

State:  
Market:

DC  
Small Group

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.  
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.  
To validate, select the Validate button or Ctrl + Shift + V.  
To finalize, select the Finalize button or Ctrl + Shift + F.

Market Level Calculations (Same for all Plans)

Section I: Experience Period Data

Experience Period: 01/01/2018 to 12/31/2018

PMPM

Allowed Claims	\$1,860,368.85	\$682.95
Reinsurance	\$0.00	\$0.00
Incurred Claims in Experience Period	\$1,659,963.78	\$609.98
Risk Adjustment	\$344,976.55	\$126.64
Experience Period Premium	\$1,344,973.73	\$493.75
Experience Period Member Months	2,724	

Section II: Projections

Benefit Category	Experience Period Index Rate PMPM	Year 1 Trend			Year 2 Trend			Trended EHB Allowed Claims PMPM
		Cost	Utilization		Cost	Utilization		
Inpatient Hospital	\$207.56	1.099	1.028		1.099	1.038		\$245.99
Outpatient Hospital	\$64.54	1.041	1.068		1.041	1.068		\$79.78
Professional	\$117.60	1.015	1.063		1.015	1.063		\$136.30
Other Medical	\$155.85	1.061	1.068		1.061	1.068		\$188.30
Capitation	\$0.00	1.000	1.000		1.000	1.000		\$0.00
Prescription Drug	\$149.41	1.117	1.033		1.117	1.033		\$186.86
Total	\$682.95							\$838.33
Morbidity Adjustment						1.855		
Demographic Shift						0.933		
Plan Design Changes						1.000		
Other						0.810		
Adjusted Trended EHB Allowed Claims PMPM for 01/01/2020						\$747.68		
Manual EHB Allowed Claims PMPM						\$512.89		
Applied Credibility %						23.00%		
Projected Period Totals								
Projected Index Rate for 01/01/2020						\$566.75		\$28,317.50
Reinsurance						\$0.00		\$0.00
Risk Adjustment Payment/Charge						\$23.86		\$1,188.00
Exchange User Fees						\$0.00		\$0.00
Market Adjusted Index Rate						\$542.79		\$27,195.50
Projected Member Months								50

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A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE
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204																														

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.  
To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.  
To validate, select the Validate button or Ctrl + Shift + I.  
To finalize, select the Finalize button or Ctrl + Shift + F.

State: DC  
Market: Small Group

## Field # Section I: General Product and Plan Information

Worksheet 1 Totals												
Section II: Experience Period and Current Plan Level Information												
2.1 Plan ID (Standard Component ID)		Total	73987DC0040017	73987DC0040021	73987DC0040057	73987DC0040046	73987DC0040029	73987DC0040056	73987DC0040058	73987DC0040040		
\$1,860,369	2.1 Allowed Claims	\$1,860,369	\$327,099	\$1,406,731	\$511	\$28,656	\$44,538	\$52,853	\$0	\$0		
50	2.1 Reinsurance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		
24	2.4 Member Cost Sharing	\$200,405	\$29,698	\$99,658	\$432	\$13,290	\$23,189	\$38,138	\$0	\$0		
	2.5 Cost Sharing Reduction	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		
\$1,659,964	2.6 Incurred Claims	\$1,659,964	\$297,361	\$1,311,073	\$79	\$15,366	\$21,369	\$14,715	\$0	\$0		
\$344,979	2.7 Risk Adjustment Transfer Amount	\$344,979	\$53,976	\$645,568	\$613	\$69,858	\$52,012	\$124,131	\$0	\$0		
\$1,344,974	2.8 Premium	\$1,344,974	\$285,780	\$627,178	\$1,043	\$121,077	\$102,790	\$207,105	\$0	\$0		
2,724	2.9 Experience Period Member Months	2,724	585	1,311	3	243	195	567	0	0		
	2.10 Current Enrollment	850	151	151	33	151	33	180	151	0		
	2.11 Current Premium PMPM	\$387.71	\$483.37	\$436.96	\$321.25	\$423.67	\$356.56	\$255.77	\$453.50	\$0		
	2.12 Loss Ratio	98.23%	128.28%	103.01%	18.42%	30.00%	42.08%	17.74%	#DIV/0!	#DIV/0!		
Per Member Per Month												
2.13 Allowed Claims		\$682.95	\$559.08	\$1,243.79	\$170.41	\$117.92	\$228.50	\$93.22	#DIV/0!	#DIV/0!		
2.14 Reinsurance		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	#DIV/0!	#DIV/0!		
2.15 Member Cost Sharing		\$73.57	\$50.77	\$84.58	\$144.00	\$54.69	\$118.92	\$67.26	#DIV/0!	#DIV/0!		
2.16 Cost Sharing Reduction		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	#DIV/0!	#DIV/0!		
2.17 Incurred Claims		\$609.18	\$568.31	\$1,159.22	\$26.41	\$21.23	\$109.58	\$24.95	#DIV/0!	#DIV/0!		
2.18 Risk Adjustment Transfer Amount		\$126.64	-\$92.27	\$570.79	-\$204.32	-\$287.48	-\$266.73	-\$121.93	#DIV/0!	#DIV/0!		
2.19 Premium		\$493.75	\$488.51	\$554.53	\$347.75	\$496.26	\$527.13	\$385.26	#DIV/0!	#DIV/0!		

3.1 Plan ID (Standard Component ID)	739870CD040017	739870CD040021	739870CD040037	739870CD040046	739870CD040029	739870CD040056	739870CD040065	739870CD040080	739870CD040088
3.2 Market Adjusted Index Rate				5542.79					
3.3 2d and Cost Sharing Design of Plan	0.9317	0.9407	0.7630	0.8657	0.8046	0.6202	0.6808	0.8000	0.8000
3.4 Provider Network Adjustment	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
3.5 Benefits in Addition to EHB	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
<b>Administrative Costs</b>									
3.6 Administrative Expense	9.91%	9.91%	9.91%	9.91%	9.91%	9.91%	9.91%	9.91%	9.91%
3.7 Taxes and Fees	7.12%	7.12%	7.12%	7.12%	7.12%	7.12%	7.12%	7.12%	7.12%
3.8 Profit & Risk Load	4.31%	4.31%	4.31%	4.31%	4.31%	4.31%	4.31%	4.31%	4.31%
3.9 Catastrophic Adjustment	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
3.10 Plan Adjusted Index Rate	\$642.92	\$649.13	\$525.12	\$597.37	\$555.21	\$427.97	\$607.24	\$557.00	\$557.00
3.11 Age Calibration Factor	0.9285				0.9285				
3.12 Geographic Calibration Factor	0.9999				0.9999				
3.13 Tobacco Calibration Factor	1.0000				1.0000				
3.14 Calibrated Plan Adjusted Index Rate	\$596.89	\$602.65	\$487.53	\$554.61	\$515.46	\$397.33	\$563.77	\$517.00	\$517.00

4.1 Plan (All Component Component ID)	Total	73877DC0040017	73877DC0040021	73877DC0040025	73877DC0040046	73877DC0040029	73877DC0040056	73877DC0040058	73877DC0040059
4.1 Allowed Claims	\$28,340	\$5,273	\$5,324	\$532	\$5,344	\$562	\$5,547	\$5,023	\$5
4.2 Reinsurance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4.3 Member Cost Sharing	\$4,674	\$518	\$526	\$100	\$928	\$106	\$1,680	\$1,784	\$1
4.5 Cost Sharing Reduction	\$6,837	\$953	\$1,077	\$149	\$1,093	\$161	\$2,160	\$2,074	\$1
4.6 Incurred Claims	\$16,830	\$3,799	\$3,721	\$282	\$3,323	\$295	\$1,706	\$3,405	\$2
4.7 Risk Adjustment Transfer Amount	\$1,000	\$178	\$178	\$20	\$180	\$20	\$245	\$179	\$0
4.8 Premium	\$28,816	\$5,786	\$5,842	\$525	\$5,376	\$555	\$4,788	\$5,465	\$5
4.9 Projected Member Months	\$0	\$1	\$1	\$1	\$1	\$1	\$1	\$1	\$1
4.10 Loss Ratio	56.44%	63.69%	61.81%	51.80%	59.80%	51.26%	34.60%	60.32%	51.52%
<b>Per Member Per Month</b>									
4.11 Allowed Claims	\$566.81	\$985.63	\$991.52	\$531.56	\$993.77	\$562.25	\$504.23	\$578.07	\$559
4.12 Reinsurance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
4.13 Member Cost Sharing	\$93.48	\$57.61	\$58.39	\$100.28	\$100.15	\$152.75	\$79.33	\$79.33	\$100
4.14 Cost Sharing Reduction	\$136.73	\$105.91	\$119.65	\$148.84	\$121.43	\$161.13	\$196.35	\$196.30	\$160
4.15 Incurred Claims	\$336.59	\$142.52	\$143.49	\$282.44	\$369.18	\$294.90	\$155.13	\$378.33	\$297
4.16 Risk Adjustment Transfer Amount	\$20.01	\$3.62	\$3.62	\$2.00	\$2.00	\$2.00	\$4.08	\$3.62	\$0.00
4.17 Premium	\$576.31	\$642.91	\$649.13	\$525.12	\$597.37	\$555.25	\$427.96	\$567.31	\$557

Rating Area Data Collection

Specify the total number of Rating  
Select only the Rating Areas you are  
To validate, select the Validate button  
To finalize, select the Finalize button

Rating Area	Rating Factor
Rating Area 1	1.0000

*Areas in your State by selecting the Create Rating Areas button or Ctrl + Shift + R.  
re offering plans within and add a factor for each area.  
tton or Ctrl + Shift + I.  
on or Ctrl + Shift + F.*

## Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Name of Company      Aetna Health, Inc.  
 SERFF tracking number    AETN-131944461  
 Submission Date        May 24, 2019  
 Product Name            DC AHI HMO SG 2020  
 Market Type            ☐ Individual      ☒ Small Group  
 Rate Filing Type        ☒ Rate Increase    ☐ New Filing

### Scope and Range of the Increase:

The 16.1% increase is requested because:

Rates are updated to reflect the impact of medical trend, revisions to our assumptions about population morbidity and projected population, changes in cost sharing levels to ensure compliance with Actuarial Value requirements, and changes in provider networks and contracts.

This filing will impact:

# of policyholder's 124

# of covered lives 177

The average, minimum and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 16.1 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved 3.37 %
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 31.4 %

Individuals within the group may vary from the aggregate of the above increase components as a result of:

the benefit plan the individual chooses, when the member's group contract renews, the age and family size and age for enrolling employees and employer contributions.

### Financial Experience of Product

The overall financial experience of the product includes:

The 2018 experience generated by the plans offered under this product produced a loss ratio that was unfavorable to the target loss ratio before and after risk adjustment. Due to the low volume of members that have enrolled in these plans the 2018 experience is not credible.

The rate increase will affect the projected financial experience of the product by:

The rate revision is not expected to impact the profitability of the product. That is, the target profit margin is unchanged

### **Components of Increase**

The request is made up of the following components:

*Trend Increases* – 101. % of the 16.1 % total filed increase

1. Medical Utilization Changes – Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

This component is 50.8 % of the 16.1 % total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

This component is 50.9 % of the 16.1 % total filed increase.

*Other Increases* – -1.7 % of the 16.1 % total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

This component is -11.1 % of the 16.1 % total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

This component is 0 % of the 16.1 % total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

This component is 12.8 % of the 16.1 % total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

This component is 0.0 % of the 16.1 % total filed increase.

5. Other – Defined as:

Changes in commission, benefit slope, risk adjustment, provider contracting, experience and population risk.

This component is -2.6 % of the 16.1 % total filed increase.

## Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Name of Company      Aetna Health, Inc.

SERFF tracking number    AETN-131944461

Submission Date        May 24, 2019

Product Name          DC AHI HMO SG 2020

Market Type            ☐ Individual      ☒ Small Group

Rate Filing Type        ☒ Rate Increase    ☐ New Filing

### Scope and Range of the Increase:

The 19.3% increase is requested because:

Rates are updated to reflect the impact of medical trend, revisions to our assumptions about population morbidity and projected population, changes in cost sharing levels to ensure compliance with Actuarial Value requirements, and changes in provider networks and contracts.

This filing will impact:

# of policyholder's 124

# of covered lives 177

The average, minimum and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 19.3 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved 6.2 %
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 35.0 %

Individuals within the group may vary from the aggregate of the above increase components as a result of:

the benefit plan the individual chooses, when the member's group contract renews, the age and family size and age for enrolling employees and employer contributions.

### Financial Experience of Product

The overall financial experience of the product includes:

The 2018 experience generated by the plans offered under this product produced a loss ratio that was unfavorable to the target loss ratio before and after risk adjustment. Due to the low volume of members that have enrolled in these plans the 2018 experience is not credible.

The rate increase will affect the projected financial experience of the product by:

The rate revision is not expected to impact the profitability of the product. That is, the target profit margin is unchanged

### **Components of Increase**

The request is made up of the following components:

*Trend Increases* – 85.1 % of the 19.3 % total filed increase

1. Medical Utilization Changes – Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

This component is 42.5 % of the 19.3 % total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

This component is 42.6 % of the 19.3 % total filed increase.

*Other Increases* – 14.9 % of the 19.3 % total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

This component is -10.1 % of the 19.3 % total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

This component is 0 % of the 19.3 % total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

This component is 10.7 % of the 19.3 % total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

This component is 0.0 % of the 19.3 % total filed increase.

5. Other – Defined as:

Changes in commission, benefit slope, risk adjustment, provider contracting, experience and population risk.

This component is 14.5 % of the 19.3 % total filed increase.



Aetna Health Inc. (a PA corp.)  
HIOS ISSUER ID: 73987

Exhibit A  
Product Portfolio & Projected Membership Distribution

HIOS Plan-ID	Network	Plan	Metallic Tier	Actuarial Value	Exchange Offering	Projected Membership Distribution
73987DC0040017	HMO	DC Gold HNOOnly 70% \$25/40 T	Gold	81.92%	Yes	18.00%
73987DC0040021	HMO	DC Gold HNOOnly 500 90% \$25/40 E	Gold	79.77%	Yes	18.00%
73987DC0040057	HMO	DC Silver HNOOnly 4800 80% \$25/40 E	Silver	72.00%	Yes	2.00%
73987DC0040046	HMO	DC Gold HNOOnly 1650 100% HSA T	Gold	79.55%	Yes	18.00%
73987DC0040029	HMO	DC Silver HNOOnly 3000 100% HSA E	Silver	71.34%	Yes	2.00%
73987DC0040056	HMO	DC Bronze HNOOnly 6000 80% \$15/50 E	Bronze	61.06%	Yes	22.00%
73987DC0040058	HMO	DC Gold HNOOnly 1500 90% E	Gold	79.17%	Yes	18.00%
73987DC0040059	HMO	DC Silver HNOOnly 2800 90% HSA E	Silver	71.31%	Yes	2.00%

Aetna Health Inc. (a PA corp.)  
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Exhibit E-1  
Calculation of Market Adjusted Index Rate

Projected Index Rate:	\$563.77
Net Risk Adjustment:	0.956
Exchange User Fees:	1.000
Total Impact:	-0.044
Market Adjusted Index Rate:	\$539.19

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Exhibit E-2  
Calculation of Plan Adjusted Index Rates and Calibrated Plan Adjusted Index Rates

			(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	
			= Product (Columns 1-6)						= Product (Columns 8-11)				= (7) x (12)		= (7) / (11)		
HIOS ID	Plan Name	Metal Tier	Membership	Market Adjusted Index Rate	AV & Cost Sharing	Distribution & Admin	Network & UM	Benefits in addition to EHBs	Impact of Eligibility (CAT)	Plan Adjusted Index Rate	Tobacco Calibration Factor	Age Calibration Factor	Geography Calibration Factor	Trend Factor	Calibration Factor	Calibrated Plan Adjusted Index Rate	AV Pricing Value
73987DC0040017	DC Gold HNOnly 70% \$25/40 T	Gold	18.00%	\$539.19	0.932	1.276	1.000	1.000	1.000	640.78	1.000	0.929	1.000	0.977	0.907	581.10	1.188
73987DC0040021	DC Gold HNOnly 500 90% \$25/40 E	Gold	18.00%	\$539.19	0.941	1.276	1.000	1.000	1.000	646.98	1.000	0.929	1.000	0.977	0.907	586.72	1.200
73987DC0040057	DC Silver HNOnly 4800 80% \$25/40 E	Silver	2.00%	\$539.19	0.761	1.276	1.000	1.000	1.000	523.38	1.000	0.929	1.000	0.977	0.907	474.63	0.971
73987DC0040046	DC Gold HNOnly 1650 100% HSA T	Gold	18.00%	\$539.19	0.866	1.276	1.000	1.000	1.000	595.39	1.000	0.929	1.000	0.977	0.907	539.93	1.104
73987DC0040029	DC Silver HNOnly 3000 100% HSA E	Silver	2.00%	\$539.19	0.805	1.276	1.000	1.000	1.000	553.41	1.000	0.929	1.000	0.977	0.907	501.87	1.026
73987DC0040056	DC Bronze HNOnly 6000 80% \$15/50 E	Bronze	22.00%	\$539.19	0.620	1.276	1.000	1.000	1.000	426.54	1.000	0.929	1.000	0.977	0.907	386.81	0.791
73987DC0040058	DC Gold HNOnly 1500 90% E	Gold	18.00%	\$539.19	0.880	1.276	1.000	1.000	1.000	605.24	1.000	0.929	1.000	0.977	0.907	548.86	1.122
73987DC0040059	DC Silver HNOnly 2800 90% HSA E	Silver	2.00%	\$539.19	0.808	1.276	1.000	1.000	1.000	555.92	1.000	0.929	1.000	0.977	0.907	504.14	1.031

Aetna Health Inc. (a PA corp.)  
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Exhibit 1  
2020 Rate Increases by Product

Product	Average Rate Increase	Minimum Rate Increase	Maximum Rate Increase
HealthNetworkOnlyOpenAccess	16.2%	4.6%	30.8%

Aetna Health Inc. (a PA corp.)  
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Exhibit 2  
Claim Impact due to Demographic Changes

Age	Experience Period Distribution		Experience Demographic Factor		Projected Period Distribution		Projection Demographic Factor	
	Male	Female	Male	Female	Male	Female	Male	Female
0	0.37%	0.29%	1.050	0.939	0.56%	0.46%	1.050	0.939
1	0.33%	0.77%	1.050	0.939	0.57%	0.49%	1.050	0.939
2	0.37%	0.73%	0.601	0.596	0.71%	0.49%	0.601	0.596
3	0.18%	0.29%	0.601	0.596	0.57%	0.50%	0.601	0.596
4	0.48%	0.26%	0.601	0.596	0.56%	0.51%	0.601	0.596
5	0.15%	0.62%	0.570	0.565	0.64%	0.56%	0.570	0.565
6	0.00%	0.00%	0.570	0.565	0.56%	0.55%	0.570	0.565
7	0.00%	0.40%	0.570	0.565	0.65%	0.50%	0.570	0.565
8	0.00%	0.51%	0.570	0.565	0.64%	0.67%	0.570	0.565
9	0.04%	0.00%	0.570	0.565	0.56%	0.67%	0.570	0.565
10	0.00%	0.00%	0.578	0.565	0.63%	0.70%	0.578	0.565
11	0.33%	0.29%	0.578	0.565	0.62%	0.61%	0.578	0.565
12	0.11%	0.15%	0.578	0.565	0.62%	0.63%	0.578	0.565
13	0.04%	0.04%	0.578	0.565	0.75%	0.60%	0.578	0.565
14	0.37%	0.55%	0.578	0.565	0.73%	0.59%	0.578	0.565
1	0.00%	0.00%	0.606	0.615	0.64%	0.63%	0.606	0.615
16	0.00%	0.00%	0.606	0.615	0.82%	0.67%	0.606	0.615
17	0.15%	0.00%	0.606	0.615	0.84%	0.63%	0.606	0.615
18	0.00%	0.00%	0.606	0.615	0.70%	0.64%	0.606	0.615
19	0.11%	0.00%	0.606	0.615	0.57%	0.70%	0.606	0.615
20	0.92%	0.62%	0.451	0.741	0.57%	0.77%	0.451	0.741
21	0.29%	0.44%	0.451	0.741	0.78%	0.67%	0.451	0.741
22	0.40%	0.51%	0.451	0.741	0.62%	0.64%	0.451	0.741
23	0.62%	1.62%	0.451	0.741	0.68%	0.75%	0.451	0.741
24	0.70%	0.88%	0.451	0.741	0.64%	0.66%	0.451	0.741
25	0.48%	0.88%	0.460	1.106	0.73%	0.79%	0.460	1.106
26	1.25%	2.53%	0.460	1.106	0.76%	0.99%	0.460	1.106
27	1.69%	1.84%	0.460	1.106	0.87%	0.92%	0.460	1.106
28	2.13%	1.40%	0.460	1.106	0.92%	0.94%	0.460	1.106
29	3.12%	1.21%	0.460	1.106	0.72%	0.93%	0.460	1.106
30	2.46%	2.17%	0.519	1.197	0.74%	0.91%	0.519	1.197
31	1.47%	0.70%	0.519	1.197	0.86%	0.95%	0.519	1.197
32	2.02%	0.40%	0.519	1.197	0.86%	0.97%	0.519	1.197
33	1.54%	0.70%	0.519	1.197	0.87%	0.98%	0.519	1.197
34	2.61%	1.03%	0.519	1.197	0.97%	0.87%	0.519	1.197
35	2.24%	0.62%	0.630	1.197	0.87%	1.03%	0.630	1.197
36	1.28%	0.15%	0.630	1.197	0.98%	1.03%	0.630	1.197
37	0.77%	0.84%	0.630	1.197	1.07%	1.04%	0.630	1.197
38	1.25%	1.06%	0.630	1.197	1.01%	0.87%	0.630	1.197
39	1.69%	1.69%	0.630	1.197	0.79%	0.83%	0.630	1.197
40	1.06%	0.95%	0.790	1.197	0.79%	0.82%	0.790	1.197
41	1.21%	0.40%	0.790	1.197	0.86%	0.94%	0.790	1.197
42	1.06%	0.70%	0.790	1.197	0.83%	0.84%	0.790	1.197
43	1.03%	0.62%	0.790	1.197	0.81%	0.73%	0.790	1.197
44	1.14%	0.00%	0.790	1.197	0.78%	0.78%	0.790	1.197
45	0.66%	0.00%	1.000	1.269	0.83%	0.81%	1.000	1.269
46	0.84%	0.62%	1.000	1.269	1.02%	0.85%	1.000	1.269
47	0.07%	0.26%	1.000	1.269	0.86%	0.86%	1.000	1.269
48	0.00%	0.26%	1.000	1.269	0.91%	0.88%	1.000	1.269
49	0.66%	0.66%	1.000	1.269	0.92%	0.97%	1.000	1.269
50	1.14%	0.29%	1.370	1.460	1.02%	0.75%	1.370	1.460
51	0.66%	0.48%	1.370	1.460	1.01%	0.92%	1.370	1.460
52	0.29%	0.88%	1.370	1.460	0.95%	0.92%	1.370	1.460
53	0.51%	0.51%	1.370	1.460	0.93%	0.93%	1.370	1.460
54	1.14%	2.31%	1.370	1.460	1.11%	0.86%	1.370	1.460
55	0.59%	1.28%	1.757	1.745	1.03%	0.85%	1.757	1.745
56	1.36%	1.43%	1.757	1.745	0.87%	0.75%	1.757	1.745
57	1.32%	0.37%	1.757	1.745	0.81%	0.72%	1.757	1.745
58	1.10%	0.37%	1.757	1.745	0.90%	0.73%	1.757	1.745
59	0.51%	1.80%	1.757	1.745	0.80%	0.69%	1.757	1.745
60	0.33%	1.14%	2.218	2.128	0.75%	0.62%	2.218	2.128
61	0.62%	1.03%	2.218	2.128	0.68%	0.63%	2.218	2.128
62	0.84%	0.95%	2.218	2.128	0.61%	0.58%	2.218	2.128
63	0.62%	0.29%	2.218	2.128	0.47%	0.40%	2.218	2.128
64	1.25%	0.11%	2.218	2.128	0.40%	0.34%	2.218	2.128
65+	2.02%	2.06%	3.200	2.700	0.71%	0.60%	3.200	2.700

Experience Period Demographic Factor	1.1248
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Note:

Experience Period Demographic Factor computed as the weighted average of gender specific Demographic Factor by current population distribution.

Projected Demographic Factor	1.0443
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Note:

Projected Demographic Factor computed as the weighted average of gender specific Demographic Factor by projected population distribution.

Demographic Change	0.9285
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Note:

Claim Impact due to Demographic Changes computed as the ratio of the Projected Demographic Factor over the Experience Period Demographic Factor.

Aetna Health Inc. (a PA corp.)  
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Exhibit 3  
Projected Membership Distribution by County

Rating Area	Counties	Experience Period Membership	Experience Period Area Factor	Projected Membership	Projected Area Factor
1	District of Columbia	100%	1.000	100%	1.000

Average Experience Period Area Factor	1.0000
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**Note:**

Average Experience Period Area Factor computed as the weighted average of Experience Period Area Factors by experience period membership distribution.

Average Projected Area Factor	1.0000
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**Note:**

Projected Area Factor computed as the weighted average of Projection Period Area Factors by projected membership distribution.

Area Shift Factor	1.0000
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**Note:**

Area Shift Factor computed as the ratio of the Projected Membership by Area over the Experience Membership by Area Factor represents:

The impact due to the shift of the population distribution across areas.

Area Factor Change	1.0000
--------------------	--------

**Note:**

Area Factor Change computed as the ratio of the Projected Area Factor over the Experience Area Factor both using experience membership

Factor represents:

The impact due to cost relativity changes, including changes to provider networks and contracts, from the experience period to the rating period.

Aetna Health Inc. (a PA corp.)  
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Exhibit 4  
Projected Membership and Paid to Allowed by Metal Tier

Metallic Tier	Projected Membership	Projected Paid to Allowed Ratio
Platinum	0	N/A
Gold	36	88%
Silver	3	82%
Bronze	11	70%
Catastrophic	0	N/A
<b>Total</b>	50	84%

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Exhibit 5  
Retention as a Percent of Premium and PMPM

Retention Components	% of Premium	PMPM
Administrative Expense Load	10.18%	\$57.14
Profit & Risk Load	4.31%	\$24.18
Premium Tax	3.34%	\$18.74
User Exchange Fee	0.00%	\$0.00
State Based Exchange Fee	0.00%	\$0.00
HIF	2.60%	\$14.59
Risk Adjustment User Fee	0.03%	\$0.18
Federal Income Tax	1.15%	\$6.43
Total Taxes and Fees	7.12%	\$39.94



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**Exhibit 6**  
**MLR Projection**

			Formula
(a)	Premium (pmpm)	\$561.07	
(b)	Medical Cost (pmpm)	\$437.01	
(c)	Medical Benefit Ratio (MBR)	77.9%	= (c) / (b)
(d)	Quality Improvement Action (pmpm)	\$4.49	= (a) x 0.80%
(e)	Taxes and Fees (pmpm)	\$42.74	
(f)	Adjusted Premium (pmpm)	\$518.33	=(a) - (e)
(g)	Adjusted Claims (pmpm)	\$441.49	= (b) + (d)
	<b>Medical Loss Ratio (MLR)</b>	<b>85.2%</b>	=(g) / (f)

Notes:

ACA adjustments for QIA and taxes and fees are estimates based on historical experience and projected expenses.

Values reflect current actuarial projections and will differ from the final reported MLR.

This projection applies to the products included in this filing and is a standalone calculation for the 2020 calendar year. This projection differs from the MLR calculation specified by PPACA which includes three years of experience for all business in the MLR pool.

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Exhibit 7  
Quarterly Trend Factors

Effective Quarter	Membership	Med Trend + HIF Factor	Index Rate
1Q 2019	63.1%	1.000	\$550.68
2Q 2019	8.9%	1.029	\$566.91
3Q 2019	14.0%	1.060	\$583.62
4Q 2019	14.1%	1.091	\$600.82
Total	100.0%	1.024	\$563.77

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Exhibit 8  
Trend Exhibit

Service Type	Unit Cost	Utilization	Total
Facility Inpatient	5.9%	2.8%	8.9%
Facility Outpatient	4.1%	6.8%	11.2%
Physician	1.5%	6.3%	7.9%
Capitation	0.0%	0.0%	0.0%
Medical	4.2%	5.2%	9.6%
Pharmacy	11.7%	3.3%	15.4%
Total (Med + Rx)	5.8%	4.8%	10.8%

**Aetna Health Inc. (a PA corp.)****HIOS ISSUER ID: 73987****Exhibit 9****Sample Rate Calculation**

The following steps outline the mathematical formula used to develop the member level rates for a sample small group. The input assumptions and the census provided below are for illustrative purposes only.

**Sample Small Group Information:**

Effective Date: 01/01/2020  
 Rating Area: Rating Area 1  
 Plan: DC Silver HNOly 4800 80% \$25/40 E

<b><u>Group Census</u></b>	<b>Employee <u>Age</u></b>	<b>Spouse <u>Age</u></b>	<b>Child 1 <u>Age</u></b>	<b>Child 2 <u>Age</u></b>	<b>Child 3 <u>Age</u></b>
Employee 1	35	36	5	7	
Employee 2	56	52			
Employee 3	24	21			
Employee 4	52	49	19	17	16
Employee 5	65	65	25		
Employee 6	58	60	24		
Employee 7	56	51			
Employee 8	42	41			
Employee 9	33	34	5	6	7
Employee 10	25	28	2	1	

**Age and Tobacco****Factors****Age Factors**

	<b>Employee</b>	<b>Spouse</b>	<b>Child 1</b>	<b>Child 2</b>	<b>Child 3</b>
Employee 1	0.876	0.896	0.654	0.654	
Employee 2	1.801	1.545			
Employee 3	0.727	0.727			
Employee 4	1.545	1.377	0.654	0.654	0.654
Employee 5	2.181	2.181	0.727		
Employee 6	1.944	2.099	0.727		
Employee 7	1.801	1.487			
Employee 8	1.053	1.013			
Employee 9	0.836	0.856	0.654	0.654	0.654
Employee 10	0.727	0.744	0.654	0.654	

### Calculation of Monthly Premium

Step 1: Multiply Market Base Rate x Rating Area Factor x Plan Factor x Effective Date Factor

Market Base Rate =	\$623.78
x Rating Area Factor (Rating Area 1)	1.0000
x Plan Factor	0.7609
x Effective Date Factor	1.0000
Market Base Rate adjusted for Plan/Area/Effective Date =	\$474.63

Step 2: Multiply Adjusted Market Base Rate in Step 1 by the Member level Age and Tobacco Factors:

Member Monthly Rates	Employee	Spouse	Child 1	Child 2	Child 3	Total
Employee 1	\$415.78	\$425.27	\$310.41	\$310.41		\$1,461.87
Employee 2	\$854.81	\$733.31				\$1,588.12
Employee 3	\$345.06	\$345.06				\$690.12
Employee 4	\$733.31	\$653.57	\$310.41	\$310.41	\$310.41	\$2,318.11
Employee 5	\$1,035.17	\$1,035.17	\$345.06			\$2,415.40
Employee 6	\$922.69	\$996.26	\$345.06			\$2,264.01
Employee 7	\$854.81	\$705.78				\$1,560.59
Employee 8	\$499.79	\$480.80				\$980.59
Employee 9	\$396.79	\$406.29	\$310.41	\$310.41	\$310.41	\$1,734.31
Employee 10	\$345.06	\$353.13	\$310.41	\$310.41		\$1,319.01
<b>Group Total Monthly Premium:</b>						<b>\$16,332.13</b>

Note: Member level monthly rates are rounded to the nearest penny.

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**Exhibit 10**  
**Plan Mapping**

<b>2018 HIOS Plan ID</b>	<b>2018 Plan Name</b>	<b>2019 HIOS Plan ID</b>	<b>2019 Plan Name</b>	<b>2020 HIOS Plan ID</b>	<b>2020 Plan Name</b>
73987DC0040056	DC Bronze HMO 5000 80% HSA E	73987DC0040056	DC Bronze HMO 6000 80% HSA E	73987DC0040056	DC Bronze HNOOnly 6000 80% \$15/50 E
73987DC0040017	DC Gold HMO 70%	73987DC0040017	DC Gold HMO 70% T	73987DC0040017	DC Gold HNOOnly 70% \$25/40 T
73987DC0040021	DC Gold HMO 500 90%	73987DC0040021	DC Gold HMO 500 90% E	73987DC0040021	DC Gold HNOOnly 500 90% \$25/40 E
73987DC0040029	DC Silver HMO 3000 100% HSA E	73987DC0040029	DC Silver HMO 3000 100% HSA E	73987DC0040029	DC Silver HNOOnly 3000 100% HSA E
73987DC0040046	DC Gold HMO 1600 100% HSA T	73987DC0040046	DC Gold HMO 1600 100% HSA T	73987DC0040046	DC Gold HNOOnly 1650 100% HSA T
73987DC0040057	DC Silver HMO 4500 80%	73987DC0040057	DC Silver HMO 4800 80% E	73987DC0040057	DC Silver HNOOnly 4800 80% \$25/40 E
		73987DC0040058	DC Gold HMO 1000 100% E	73987DC0040058	DC Gold HNOOnly 1500 90% E
				73987DC0040059	DC Silver HNOOnly 2800 90% HSA E

**Aetna Life Insurance Company**  
**HIOS ISSUER ID: 77422**

**Exhibit 11**  
**Projected Age/Gender Distribution**

Age	Male	Female	DC Age Factor
0-14	9.34%	8.49%	0.654
15	0.64%	0.63%	0.654
16	0.81%	0.66%	0.654
17	0.84%	0.63%	0.654
18	0.69%	0.64%	0.654
19	0.56%	0.69%	0.654
20	0.57%	0.77%	0.654
21	0.78%	0.67%	0.727
22	0.62%	0.64%	0.727
23	0.68%	0.75%	0.727
24	0.64%	0.66%	0.727
25	0.73%	0.79%	0.727
26	0.76%	0.99%	0.727
27	0.87%	0.92%	0.727
28	0.92%	0.94%	0.744
29	0.72%	0.93%	0.760
30	0.74%	0.91%	0.779
31	0.86%	0.95%	0.799
32	0.86%	0.97%	0.817
33	0.87%	0.98%	0.836
34	0.97%	0.87%	0.856

<b>Age Calibration Factor</b>	1.077
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**Note:**

Age Calibration Factor  
computed as the weighted average of  
HHS Age Factor by projected membership  
distribution.

<b>Weighted Average Age</b>	43
-----------------------------	----

**Note:**

This is the age that most closely  
corresponds to the age calibration factor.

35	0.87%	1.03%	0.876
36	0.98%	1.03%	0.896
37	1.07%	1.04%	0.916
38	1.01%	0.87%	0.927
39	0.79%	0.83%	0.938
40	0.79%	0.82%	0.975
41	0.86%	0.94%	1.013
42	0.83%	0.84%	1.053
43	0.81%	0.73%	1.094
44	0.78%	0.78%	1.137
45	0.83%	0.81%	1.181
46	1.02%	0.85%	1.227
47	0.86%	0.86%	1.275
48	0.91%	0.88%	1.325
49	0.92%	0.97%	1.377
50	1.02%	0.75%	1.431
51	1.01%	0.92%	1.487
52	0.95%	0.92%	1.545
53	0.93%	0.93%	1.605
54	1.11%	0.86%	1.668
55	1.03%	0.85%	1.733
56	0.87%	0.75%	1.801
57	0.81%	0.72%	1.871
58	0.90%	0.73%	1.944
59	0.80%	0.69%	2.020
60	0.75%	0.62%	2.099
61	0.68%	0.63%	2.180
62	0.61%	0.58%	2.180
63	0.47%	0.40%	2.180
64	0.40%	0.34%	2.180
65+	0.71%	0.60%	2.180



**Aetna Health Inc. (a PA corp.)**  
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**Exhibit 12**  
**Comparison of Key Pricing Factors to LY (2020) Pricing**

Category	2019	2020	% Impact to Premium	Description
Base Experience PMPM*	\$275.58	\$377.58	25.0%	Using all SG experience (HMO/PPO) from DC (23%) and IH (77%)
Pricing Trend (annual)	11.6%	12.3%	16.4%	Experience higher utilization and unit cost pressure
Morbidity	1.02	1.02	1.3%	Expecting market risk pool to deteriorate slightly
Benefit	0.992	0.979	-1.9%	Leaner portfolio in 2020 compared to 2019
Demographic	0.984	0.973	-1.9%	Expecting shift downward in age/gender factors
Area Factor	1.000	1.000	0.0%	No material change
Other	0.965	0.945	-3.6%	Ben Chg, Ded Supp, etc.
Network Change	1.046	1.046	1.6%	Adj to normalize experience for manual pricing
Risk Adjustment	-\$27.01	\$20.05	-11.5%	2020 Projection based on Wakely 2018 Accruals
<b>Projected Claim Cost</b>	<b>\$336.50</b>	<b>\$439.81</b>	<b>25.4%</b>	
<b>% of Premium Items</b>				
<b>Admin</b>	<b>10.1%</b>	<b>8.8%</b>	<b>2.1%</b>	decreasing market footprint leads to increasing admin costs PMPM
<b>Profit</b>	<b>1.6%</b>	<b>5.5%</b>	<b>6.0%</b>	
FIT	0.33%	1.15%	1.3%	
AFIT	1.23%	4.31%	4.7%	
<b>Taxes &amp; Fees</b>	<b>5.8%</b>	<b>7.3%</b>	<b>4.3%</b>	
Commissions	1.6%	1.3%	0.2%	
Prem Tax	3.3%	3.3%	1.3%	
HIF	0.0%	2.6%	3.6%	2020 HIF reinstated
Federal EUF	0.9%	0.0%	-0.9%	
State EUF	0.0%	0.0%	0.0%	N/A
PCORI	0.00%	0.03%	0.0%	No material change
<b>Total % of Prem</b>	<b>17.42%</b>	<b>21.61%</b>		
<b>Single Risk Pool Premium</b>	<b>\$407.47</b>	<b>\$561.07</b>	<b>37.7%</b>	Ties back to Wksht II Field #4.17
SG Trend Factor	1.058	1.024	-3.2%	
Index Rate	\$430.96	\$574.40		
<u>Calibration Factors</u>				
Trend	1.058	1.024		
Age	0.979	1.077		
Area	1.000	1.000		
Tobacco	1.000	1.000		
Avg 1.0 Premium	\$416.28	\$520.90		
Remove trend factor	\$393.60	\$508.81		
Consumer Premium Relativity	0.829	0.835		
Avg Prem	\$326.24	\$424.89	30.24%	
Premium Mix	1.188	1.060	-10.8%	
<b>Avg Projection Period Premium</b>	<b>\$387.71</b>	<b>\$450.24</b>	<b>16.13%</b>	Ties back to Wksht II Field # 1.13

**Footnotes**

\*Base Experience PMPM for 2019 is 2017 Claims experience used for pricing LY with 1 year of trend to bring the claim level to 2018

\*Base Experience PMPM for 2020 is 2018 Claims experience

**Aetna Health Inc. (a PA corp.)**  
**HIOS ISSUER ID: 73987**

**Exhibit A-1**  
**Rate Change by Plan**

2019 HIOS Plan ID	2019 Plan Name	1Q2019 Premium Rate	2020 HIOS Plan ID	2020 Plan Name	1Q2020 Premium Rate	Rate Change
73987DC0040058	DC Gold HMO 1000 100% E	\$379.58	73987DC0040058	DC Gold HNOOnly 1500 90% E	\$399.02	5.1%
73987DC0040021	DC Gold HMO 500 90% E	\$365.66	73987DC0040021	DC Gold HNOOnly 500 90% \$25/40 E	\$426.55	16.7%
73987DC0040046	DC Gold HMO 1600 100% HSA T	\$364.59	73987DC0040046	DC Gold HNOOnly 1650 100% HSA T	\$392.53	7.7%
73987DC0040017	DC Gold HMO 70% T	\$337.39	73987DC0040017	DC Gold HNOOnly 70% \$25/40 T	\$422.46	25.2%
73987DC0040056	DC Bronze HMO 6000 80% HSA E	\$213.99	73987DC0040056	DC Bronze HNOOnly 6000 80% \$15/50 E	\$281.21	31.4%
73987DC0040029	DC Silver HMO 3000 100% HSA E	\$298.39	73987DC0040029	DC Silver HNOOnly 3000 100% HSA E	\$364.86	22.3%
73987DC0040057	DC Silver HMO 4800 80% E	\$269.28	73987DC0040057	DC Silver HNOOnly 4800 80% \$25/40 E	\$345.06	28.1%

DC Gold HNOOnly 70% \$25/40 T

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐  
Apply Inpatient Copay per Day? ☐  
Apply Skilled Nursing Facility Copay per Day? ☐  
Use Separate MOOP for Medical and Drug Spending? ☐  
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier

Gold

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Deductible (\$)  
Coinsurance (%; Insurer's Cost Share)  
MOOP (\$)  
MOOP if Separate (\$)

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
\$0.00	\$0.00	
70.00%	100.00%	
\$7,600.00		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	78%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	
Specialty Rx Coinsurance Maximum: \$150	
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10):	

### Plan Description:

Name: DC Gold HNOOnly 70% \$25/40 T  
Plan HIOS ID: 73987DC0040017  
Issuer HIOS ID: 73987

### Output

Calculate

Status/Error Messages:

Actuarial Value: 81.92%

Metal Tier: Gold

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.0625 seconds

Final 2020 AV Calculator

This product, DC Gold HNOOnly 70% \$25/40 T, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 81.92%

DC Gold HNOOnly 500 90% \$25/40 E

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐  
Apply Inpatient Copay per Day? ☐  
Apply Skilled Nursing Facility Copay per Day? ☐  
Use Separate MOOP for Medical and Drug Spending? ☐  
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier

Gold

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)	\$500.00	\$0.00
Coinsurance (%; Insurer's Cost Share)	90.00%	100.00%
MOOP (\$)	\$7,900.00	
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	88%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$250.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$150
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

### Plan Description:

Name: DC Gold HNOOnly 500 90% \$25/40 E  
Plan HIOS ID: 73987DC0040021  
Issuer HIOS ID: 73987

### Output

Calculate

Status/Error Messages:

Actuarial Value: 79.77%

Metal Tier: Gold

Additional Notes:

NOTE: One or more services are not subject to the deductible and have no copay. Any service with this cost-sharing structure is covered at 100% by the plan in the deductible range. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Calculation Time:

0.0312 seconds

Final 2020 AV Calculator

This product, DC Gold HNOOnly 500 90% \$25/40 E, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.77%

DC Silver HNOnly 4800 80% \$25/40 E

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐  
Apply Inpatient Copay per Day? ☐  
Apply Skilled Nursing Facility Copay per Day? ☐  
Use Separate MOOP for Medical and Drug Spending? ☐  
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier: Silver

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)	\$4,800.00	\$0.00
Coinsurance (%; Insurer's Cost Share)	80.00%	100.00%
MOOP (\$)	\$7,900.00	
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$750.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	64%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$250.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	
Specialty Rx Coinsurance Maximum: \$150	
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10):	

### Plan Description:

Name: DC Silver HNOnly 4800 80% \$25/40 E  
Plan HIOS ID: 73987DC0040057  
Issuer HIOS ID: 73987

### Output

Calculate

### Status/Error Messages:

Actuarial Value: 72.00%

Metal Tier: Silver

### Additional Notes:

NOTE: One or more services are not subject to the deductible and have no copay. Any service with this cost-sharing structure is covered at 100% by the plan in the deductible range. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

### Calculation Time:

0.0469 seconds

### Final 2020 AV Calculator

This product, DC Silver HNOnly 4800 80% \$25/40 E, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.00%

## DC Gold HNOOnly 1650 100% HSA T

### Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

#### User Inputs for Plan Parameters

- ☒ Use Integrated Medical and Drug Deductible?  
☐ Apply Inpatient Copay per Day?  
☐ Apply Skilled Nursing Facility Copay per Day?  
☐ Use Separate MOOP for Medical and Drug Spending?  
☐ Indicate if Plan Meets CSR or Expanded Bronze AV Standard?

Desired Metal Tier: Gold

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		\$1,650.00
		90.00%
		\$3,950.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

#### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$150
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

#### Plan Description:

**Name:** DC Gold HNOOnly 1650 100% HSA T  
**Plan HIOS ID:** 73987DC0040046  
**Issuer HIOS ID:** 73987

#### Output

Calculate

#### Status/Error Messages:

**Actuarial Value:** 80.55%  
**Metal Tier:** Gold

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

#### Additional Notes:

**Calculation Time:** 0.0312 seconds

#### Final 2020 AV Calculator

**Option 3 Additive TIF adj:** -1.00%  
**Final AV:** 79.55%

This product, DC Gold HNOOnly 1650 100% HSA T, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.55%

## DC Silver HNOnly 3000 100% HSA E

### Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

#### User Inputs for Plan Parameters

- ☒ Use Integrated Medical and Drug Deductible?  
☐ Apply Inpatient Copay per Day?  
☐ Apply Skilled Nursing Facility Copay per Day?  
☐ Use Separate MOOP for Medical and Drug Spending?  
☐ Indicate if Plan Meets CSR or Expanded Bronze AV Standard?

Desired Metal Tier: **Silver**

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$3,000.00
Coinsurance (%; Insurer's Cost Share)		90.00%
MOOP (\$)		\$6,500.00
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

#### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	
Specialty Rx Coinsurance Maximum: \$150	
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10):	

#### Plan Description:

**Name:** DC Silver HNOnly 3000 100% HSA E  
**Plan HIOS ID:** 73987DC0040029  
**Issuer HIOS ID:** 73987

#### Output

Calculate

#### Status/Error Messages:

**Actuarial Value:** 71.34%  
**Metal Tier:** Silver

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

#### Additional Notes:

**Calculation Time:** 0.0449 seconds  
**Final 2020 AV Calculator**

This product, DC Silver HNOnly 3000 100% HSA E, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 71.34%

DC Bronze HNOOnly 6000 80% \$15/50 E

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒  
Apply Inpatient Copay per Day? ☒  
Apply Skilled Nursing Facility Copay per Day? ☒  
Use Separate MOOP for Medical and Drug Spending? ☐  
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier: **Bronze**

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$6,000.00
Coinsurance (%; Insurer's Cost Share)		100.00%
MOOP (\$)		\$7,900.00
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	91%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$250.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	
Specialty Rx Coinsurance Maximum: \$150	
Set a Maximum Number of Days for Charging an IP Copay? <input checked="" type="checkbox"/>	
# Days (1-10): 5	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10):	

### Plan Description:

Name: DC Bronze HNOOnly 6000 80% \$15/50 E  
Plan HIOS ID: 73987DC0040056  
Issuer HIOS ID: 73987

### Output

### Status/Error Messages:

Actuarial Value: 61.06%  
Metal Tier: Bronze

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

### Additional Notes:

Calculation Time: 0.0469 seconds

Final 2020 AV Calculator

This product, DC Bronze HNOOnly 6000 80% \$15/50 E, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.06%



DC Gold HNOOnly 1500 90% E

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐  
Apply Inpatient Copay per Day? ☐  
Apply Skilled Nursing Facility Copay per Day? ☐  
Use Separate MOOP for Medical and Drug Spending? ☐  
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier: Gold

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$0.00
Coinsurance (%; Insurer's Cost Share)	90.00%	100.00%
MOOP (\$)	\$7,500.00	
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	94%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	
Specialty Rx Coinsurance Maximum: \$150	
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10):	

### Plan Description:

Name: DC Gold HNOOnly 1500 90% E  
Plan HIOS ID: 73987DC0040058  
Issuer HIOS ID: 73987

### Output

Status/Error Messages:

Actuarial Value: 79.17%

Metal Tier: Gold

Additional Notes:

NOTE: One or more services are not subject to the deductible and have no copay. Any service with this cost-sharing structure is covered at 100% by the plan in the deductible range. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Calculation Time:

0.0312 seconds

Final 2020 AV Calculator

This product, DC Gold HNOOnly 1500 90% E, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.17%

## DC Silver HNOnly 2800 90% HSA E

### Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

#### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒  
 Apply Inpatient Copay per Day? ☐  
 Apply Skilled Nursing Facility Copay per Day? ☐  
 Use Separate MOOP for Medical and Drug Spending? ☐  
 Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier: **Silver**

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$2,800.00
Coinsurance (%; Insurer's Cost Share)		90.00%
MOOP (\$)		\$6,750.00
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

#### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	
Specialty Rx Coinsurance Maximum: \$150	
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10):	

#### Plan Description:

Name: DC Silver HNOnly 2800 90% HSA E  
 Plan HIOS ID: 73987DC0040059  
 Issuer HIOS ID: 73987

#### Output

Calculate

#### Status/Error Messages:

Actuarial Value: 71.31%  
 Metal Tier: Silver

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

#### Additional Notes:

Calculation Time: 0.0469 seconds

Final 2020 AV Calculator

This product, DC Silver HNOnly 2800 90% HSA E, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 71.31%

## Actuarial Value Certification

State: DC  
Plan Year: 2020  
HIOS Issuer ID: 73987  
HIOS Product Ids: 73987DC004

HIOS Plan Ids: 73987DC0040029

Per 156.135, the AV must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles and methodologies. There are 3 types of certification:

- (1) Option 1 - Certify that the plan was entered correctly and does not vary materially from standard options entered
- (2) Option 2 - Certify that entries into the calculator were modified to reflect the plan appropriately [156.135.(b).(2) ]
- (3) Option 3 - Used the calculator for provisions that fit and made adjustment for plan design features that deviate outside of calculator [156.135.(b).(3) ]

The plans listed meet the criteria for Option 1 - the plans were entered correctly and do not vary materially from the standard options entered.

In addition, a 0.9999 factor is applied to the average coinsurance in row 11 for most plans. While not materially impacting the entered benefit value, this methodology prevents the OP facility/physician splitting methodology from being invoked which we do not believe is appropriate for our benefit plans.

The output from this consistently-applied process reflects our certified Actuarial Values.

### Certification Language:


The development of the actuarial value was determined in accordance with the ASOPs established by the ASB and with applicable laws and regulations.

This analysis was conducted by a member of the American Academy of Actuaries that meets the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States promulgated by the American Academy of Actuaries, and has the education and experience necessary to perform the work.

The certifying actuary is an employee of Aetna.

This certification supports plans offered in the Small Group market.

Metal levels were appropriately assigned based on applicable law.

Actuary Signature:   
Actuary Printed name: Joanna Kluz, ASA, MAAA  
Date: 05/24/2019

Unique Plan Design - Issuer Actuarial Value  
Supporting Documentation and Justification

State:	DC
Plan Year:	2020
HIOS Issuer ID:	73987
HIOS Product Ids:	73987DC004

HIOS Plan Ids:	Option:	Item:
73987DC0040017	2	MH OP Split
73987DC0040021	2	MH OP Split
73987DC0040057	2	MH OP Split
73987DC0040046	3	TIF
73987DC0040056	2	MH OP Split
73987DC0040058	2	MH OP Split
73987DC0040059	2	ER Copay + Coins

1) Justification for use of Issuer AV:

Per 156.135, the AV must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles and methodologies. There are 3 types of certification:

- (1) Option 1 - Certify that the plan was entered correctly and does not vary materially from standard options entered
- (2) Option 2 - Certify that entries into the calculator were modified to reflect the plan appropriately [156.135.(b).(2) ]
- (3) Option 3 - Used the calculator for provisions that fit and made adjustment for plan design features that deviate outside of calculator [156.135.(b).(3) ]

Aetna benefit plans were analyzed vs the AVC to determine when Option 2 and/or Option 3 vs Option 1 certification was necessary. Four underlying calculators were built to support population of the Mental Health OP, Specialist OV, ER, and Rx generic rows in the AVC. These all support Option 2 certifications, but only the calculators used are referenced below. A separate calculator was used for plans with True Individual Family (TIF) deductibles in support of Option 3. Again, only if the calculator was used would it be referenced below. In addition, a 0.9999 factor is applied to the average coinsurance in row 11 for most plans. While not materially impacting the entered benefit value, this methodology prevents the OP facility/physician splitting methodology from being invoked which we do not believe is appropriate for our benefit plans. The output from this consistently-applied process reflects our certified Actuarial Values.

2) Regulatory permitted alternate method used:

- (2) Option 2 - Certify that entries into the calculator were modified to reflect the plan appropriately [156.135.(b).(2) ]
- (3) Option 3 - Used calculator for provisions that fit and made adjustment for plan design features that deviate outside of calculator [156.135.(b).(3) ]

3) Confirmation that only in-network cost sharing including multitier networks, was considered:

Confirmed. Only in-network cost sharing information was used.

4) Description of standardized plan population data used:

Detail of data used for each of the subcalculators is described below in items 5 & 6. All data was based on either the AVC continuance tables, or a national data set which is representative of the SG population

5) If the method described in 156.135.(b).(2) was used, description of how the benefits were modified to fit the parameters of the AV calculator:

MH OP Benefit Plan Fit Process

MH OP has two subcategories: MH OP - Office Visit and MH OV - All Other. The equivalent coinsurance for each was set as the plan copay divided by the unit cost. The adjusted equivalent coinsurance was then calculated for each copay/deductible combination. If there was non-uniform deductible applicability, the equivalent coinsurance was calculated that produced the same net impact as assuming both subcategories had no deductible applied. This was based on the distribution of claims cost from the AVC continuance tables, adjusted to take into account the impact of the OOP Max. The average coinsurance of the row was calculated based on the weightings of the internal subcategories.

ER Benefit Plan Fit Process

Where both an ER copay and coinsurance exist, we calculated a coinsurance equivalent amount. The copay visit costs were converted to equivalent coinsurance using the AVC continuance table average unit costs. The copay equivalent coinsurance was then multiplied by the actual coinsurance as the aggregate equivalent coinsurance.

**RATE FILING REQUIREMENTS INDIVIDUAL AND SMALL GROUP  
PLANS SOLD ON DC HEALTH LINK  
CHECK-LIST**

INSTRUCTIONS: Include all required elements in the table below with the filed rates. The data elements listed in the Actuarial Memorandum should be consistent with the cover letter, if applicable.

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
1	Purpose of Filing	State the purpose of the filing. Identify the applicable law. List the proposed changes to the base rates and rating factors, and provide a general summary.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 1
2	Form Numbers	Form numbers should be listed in the actuarial memorandum.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 11
3	HIOS Product ID	The HIOS product ID should be listed in the actuarial memorandum.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 1
4	Effective Date	The requested effective date of the rate change. For filings effective 1/1/2018 and later, follow filing due date requirements.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 1
5	Market	Indicate whether the products are sold in the individual or small employer group market.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 1
6	Status of Forms	Indicate whether the forms are open to new sales, closed, or a mixture of both, and whether the forms are grandfathered, non- grandfathered, or a mixture of both.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 1
7	Benefits/Metal level(s)	Include a basic description of the benefits of the forms referenced in the filing and the metal level of each plan design.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 1-2
Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
7.1	AV Value	Provide the actuarial value of each plan design using the AV calculator developed and made available by HHS.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 1-2, Exhibit A
8	Average Rate Increase Requested	The weighted average rate increase being requested, incremental and year-over-year renewal. The weights should be based on premium volume. <b>In the small group market, please also provide weighted average rate increase requested for 2017Q1 over 2016Q1; etc.</b>	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 2
9	Maximum Rate Increase Requested	The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 2
10	Minimum Rate Increase Requested	The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 2
11	Absolute Maximum Premium Increase	The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes such as aging.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 2
12	Average Renewal Rate Increase for a Year	Calculate the average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing. The calculation must be performed for each HIOS product ID.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 2

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
13	Rate Change History	Rate change history of the forms referenced in the filing. If nationwide experience is used in developing the rates, provide separately the rate history for District of Columbia and the nationwide average rate history.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 2-3
14	Exposure	Current number of policies, certificates and covered lives.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 3
15	Member Months	Number of members in force during each month of the base experience period used in the rate development and in each of the two preceding twelve-month periods.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 3
16	Past Experience	Provide monthly earned premium and incurred claims for the base experience period used in the rate development and each of the two preceding twelve-month periods.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 3, 10
17	Index Rate	Provide the index rate.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 3
17.1	Rate Development	Show base experience used to develop rates and all adjustments and assumptions applied to arrive at the requested rates. For less than fully credible blocks, disclose the source of the base experience data used in the rate development and discuss the appropriateness of the data for pricing the policies in the filing.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 3-5
18	Credibility Assumption	If the experience of the policies included in the filing is not fully credible, state and provide support for the credibility formula used in the rate development.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 5
19	Trend Assumption	Show trend assumptions by major types of service as defined by HHS in the Part I Preliminary Justification template, separately by unit cost, utilization, and in total. Provide the development of the trend assumptions.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 5-6
20	Cost-Sharing Changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost- sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 6
21	Benefit Changes	Disclose any changes in covered benefits for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for changes in covered benefits in the rate development. Provide support for the estimated cost impact of the benefit changes.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 6, Exhibit E-2

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
22	Plan Relativities	For rate change filings, if the rate change is not uniform for all plan designs, provide support for all requested rate changes by plan design. Disclose the minimum, maximum, and average impact of the changes on policyholders. For initial filings, provide the derivation of any new plan factors.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 6, Exhibit E-2
23	Rating Factors	Provide the age and other rating factors used. Disclose any changes to rating factors, and the minimum, maximum, and average impact on policyholders. Provide support for any changes.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 6, Exhibit 3, Exhibit 7, Exhibit 11
23.1	Wellness Programs	Describe any wellness programs (as defined in section 2705(j) of the PHS Act) included in this filing.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 6-7
24	Distribution of Rate Increases	Anticipated distribution of rate increases due to changes in base rates, plan relativities, and rating factors. This need not include changes in demographics of the individual or group.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 7, Exhibit A-1
25	Claim Reserve Needs	Provide the claims for the base experience period separately for paid claims, and estimated incurred claims (including claim reserve). Indicate the incurred period used for the base period. Indicate the paid-through date of the paid claims, and provide a basic description of the reserving methodology for claims reserves and contract reserves, if any. Provide margins used, if any.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 7
26	Administrative Costs of Programs that Improve Health Care Quality	Show the amount of administrative costs included with claims in the numerator of the MLR calculation . Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 7
Number	Data Element	Requirement Description	Individual/and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
27	Taxes and Licensing or Regulatory Fees	Show the amount of taxes, licenses, and fees subtracted from premium in the denominator of your medical loss ratio calculation(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 7, Exhibit 6
28	Medical Loss Ratio (MLR)	Demonstrate that the projected loss ratio, including the requested rate change, meets the minimum MLR. Show the premium, claims, and adjustments separately with the development of the projected premium and projected claims (if not provided in the rate development section). If the loss ratio falls below the minimum for the subset of policy forms in the filing, show that when combined with all other policy forms in the market segment in District of Columbia, the loss ratio meets the minimum.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 7, Exhibit 6

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
29	Risk Adjustment	Provide rate information relating to the Risk Adjustment program. Information should include assumed Risk Adjustment user fees, Risk Adjustment PMPM excluding user fees and assumed distribution of enrollment by risk score, plan, and geographical area. Provide support for the assumptions, including any demographic changes. Provide information/study on the development of risk scores and Risk Adjustment PMPM. Provide previous year-end estimated risk adjustment payable or receivable amount and quantitative support for the amount.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 7-8
30	Past and Prospective Loss Experience Within and Outside the State	Indicate whether loss experience within or outside the state was used in the development of proposed rates. Provide an explanation for using loss experience within or outside the state.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 8
31	A Reasonable Margin for Reserve Needs	Show the assumed Margin for Reserve Needs used in the development of proposed rates. Margin for Reserve Needs includes factors that reflect assumed contributions to the company's surplus or the assumed profit margin. Demonstrate how this assumption was derived, how the assumption has changed from prior filings, and provide support for changes. If the assumption for Qualified Health Plans exceeds 3% as assumed in the risk corridor formula, justify the excess in light of the company's surplus position.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 8, Exhibit 5
Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
32	Past and Prospective Expenses	Indicate the expense assumptions used in the development of proposed rates. Demonstrate how this assumption was derived. Show how this assumption has changed from prior filings, and provide support for any change. Provide the assumed administrative costs in the following categories: <ul style="list-style-type: none"> <li>• Salaries, wages, employment taxes, and other employee benefits</li> <li>• Commissions</li> <li>• Taxes, licenses, and other regulatory fees</li> <li>• Cost containment programs / quality improvement activities</li> <li>• All other administrative expenses</li> <li>• Total</li> </ul>	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 8
33	Any Other Relevant Factors Within and Outside the State	Show any other relevant factors that have been considered in the development of the proposed rates. Demonstrate how any related assumptions were derived. Show how these assumptions have changed from prior filings, and provide support for any change.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 8
34	Other	Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20.doc - pg 9



Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
35	Actuarial Certification	Signed and dated certification by a qualified actuary that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of the District of Columbia and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the rates are not unfairly discriminatory.	Yes	DC Small Group Actuarial Memorandum - AHI 1 Q20.doc - pg 9
36	Part I Preliminary Justification (Grandfathered Plan Filings)	Rate Summary Worksheet --- Provide this document with all Grandfathered plan filings. <b>Provide in Excel and PDF format.</b>	N/A	N/A
36.1	Unified Rate Review Template (Non-Grandfathered Filings)	Unified Rate Review Template as specified in the proposed Federal Rate Review regulation. Provide this document with all Non-Grandfathered plan filings. <b>Provide in Excel and PDF format.</b>	Yes	Supporting Documentaion
37	Part II Preliminary Justification	Written description justifying the rate increase as specified by 45 CFR § 154.215(f). Provide for <i>all</i> individual and small employer group filings (whether or not they are “subject to review” as defined by HHS).	Yes	Supporting Documentation
38	DISB Actuarial Memorandum Dataset	Summarizes data elements contained in Actuarial Memorandum. Provide this document with all Non- Grandfathered plan filings. <b>Provide in Excel format only.</b>	Yes	Supporting Documentation
39	District of Columbia Plain Language Summary	Similar to the Part II Preliminary Justification, this is a written description of the rate increase as specified by 45 CFR § 154.215, but as a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. Provide this document for all individual and small employer group filings.	Yes	Supporting Documentation
40	Summary of Components for Requested Rate Change	DISB will require that issuers provide a chart listing a) any and all components of requested rate changes from the prior year; b) a quick summary/explanation of the change; and c) the actual percentage impact of the change for each component, such that the total for all components listed equals the total percentage change requested for the plan year.	Yes	Supporting Documentation

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
41	CCIO Risk Adjustment Transfer Elements Extract (RATE 'E')	Received directly from CCIO; this report should be completed and submitted by the set deadline for QHP submissions, or by <b>April 30th</b> of the current year, whichever is first.	Yes	Supporting Documentation
42	Additional Requirements for Stand-Alone Dental Plan Filings	Provide the following for stand-alone dental plan filings: <ul style="list-style-type: none"> <li>• Identification of the level of coverage (i.e. low or high), including the actuarial value of the plan determined in accordance with the proposed rule;</li> <li>• Certification of the level of coverage by a member of the American Academy of Actuaries using generally accepted actuarial principles; and</li> <li>• Demonstration that the plan has a reasonable annual limitation on cost-sharing.</li> </ul>	N/A	N/A

#### CERTIFYING SIGNATURE

The undersigned representative of the organization submitting this rate filing attests that all items contained in the above checklist have been included in the filing to the best of the company's ability.

Joanna Kluza

(Print Name)



(Signature)

**Aetna Health Inc. (a PA corp.)**  
**HIOS ISSUER ID: 73987**

**Exhibit 12**  
**Comparison of Key Pricing Factors to LY (2020) Pricing**

Category	2019	2020	% Impact to Premium	Description
Base Experience PMPM*	\$275.58	\$377.58	25.0%	Using all SG experience (HMO/PPO) from DC (23%) and IH (77%)
Pricing Trend (annual)	11.6%	12.3%	16.4%	Experience higher utilization and unit cost pressure
Morbidity	1.02	1.05	4.8%	Expecting market risk pool to deteriorate slightly
Benefit	0.992	0.979	-2.0%	Leaner portfolio in 2020 compared to 2019
Demographic	0.984	0.973	-2.0%	Expecting shift downward in age/gender factors
Area Factor	1.000	1.000	0.0%	No material change
Other	0.965	0.945	-3.8%	Ben Chg, Ded Supp, etc.
Network Change	1.046	1.046	1.8%	Adj to normalize experience for manual pricing
Risk Adjustment	-\$27.01	\$20.01	-11.5%	2020 Projection based on Wakely 2018 Accruals
<b>Projected Claim Cost</b>	<b>\$336.50</b>	<b>\$453.32</b>	<b>28.7%</b>	
<b>% of Premium Items</b>				
<b>Admin</b>	<b>10.1%</b>	<b>8.6%</b>	<b>2.1%</b>	decreasing market footprint leads to increasing admin costs PMPM
<b>Profit</b>	<b>1.6%</b>	<b>5.5%</b>	<b>6.2%</b>	
FIT	0.33%	1.15%	1.3%	
AFIT	1.23%	4.31%	4.9%	
<b>Taxes &amp; Fees</b>	<b>5.8%</b>	<b>7.3%</b>	<b>4.5%</b>	
Commissions	1.6%	1.3%	0.2%	
Prem Tax	3.3%	3.3%	1.5%	
HIF	0.0%	2.6%	3.7%	2020 HIF reinstated
Federal EUF	0.9%	0.0%	-0.9%	
State EUF	0.0%	0.0%	0.0%	N/A
PCORI	0.00%	0.03%	0.0%	No material change
<b>Total % of Prem</b>	<b>17.42%</b>	<b>21.34%</b>		
<b>Single Risk Pool Premium (Wksht 1)</b>	<b>\$407.47</b>	<b>\$576.31</b>	<b>41.4%</b>	Ties back to Wksht II Field #4.17
SG Trend Factor	1.058	1.024	-3.2%	
Index Rate	\$430.96	\$590.01		
<u>Calibration Factors</u>				
Trend	1.058	1.024		
Age	0.979	1.077		
Area	1.000	1.000		
Tobacco	1.000	1.000		
Avg 1.0 Premium	\$416.28	\$535.05		
Remove trend factor	\$393.60	\$522.63		
Consumer Premium Relativity	0.829	0.835		
Avg Prem	\$326.24	\$436.43	33.78%	
Premium Mix	1.188	1.060	-10.8%	
<b>Avg Projection Period Premium</b>	<b>\$387.71</b>	<b>\$462.46</b>	<b>19.28%</b>	Ties back to Wksht II Field # 1.13

**Footnotes**

\*Base Experience PMPM for 2019 is 2017 Claims experience used for pricing LY with 1 year of trend to bring the claim level to 2018

\*Base Experience PMPM for 2020 is 2018 Claims experience

Aetna Health Inc. (a PA corp.)  
HIOS ISSUER ID: 73987

Exhibit A  
Product Portfolio & Projected Membership Distribution

HIOS Plan-ID	Network	Plan	Metallic Tier	Actuarial Value	Exchange Offering	Projected Membership Distribution
73987DC0040017	HMO	DC Gold HNOnly 70% \$25/40 T	Gold	81.92%	Yes	18.00%
73987DC0040021	HMO	DC Gold HNOnly 500 90% \$25/40 E	Gold	79.77%	Yes	18.00%
73987DC0040057	HMO	DC Silver HNOnly 4800 80% \$25/40 E	Silver	72.00%	Yes	2.00%
73987DC0040046	HMO	DC Gold HNOnly 1650 100% HSA T	Gold	79.55%	Yes	18.00%
73987DC0040029	HMO	DC Silver HNOnly 3000 100% HSA E	Silver	71.34%	Yes	2.00%
73987DC0040056	HMO	DC Bronze HNOnly 6000 80% \$15/50 E	Bronze	61.06%	Yes	22.00%
73987DC0040058	HMO	DC Gold HNOnly 1500 90% E	Gold	79.17%	Yes	18.00%
73987DC0040059	HMO	DC Silver HNOnly 2800 90% HSA E	Silver	71.31%	Yes	2.00%

Aetna Health Inc. (a PA corp.)  
HIOS ISSUER ID: 73987

Exhibit E-1  
Calculation of Market Adjusted Index Rate

Projected Index Rate:	\$580.28
Net Risk Adjustment:	0.958
Exchange User Fees:	1.000
Total Impact:	-0.042
Market Adjusted Index Rate:	\$555.88

Aetna Health Inc. (a PA corp.)  
HIOS ISSUER ID: 73987

Exhibit E-2  
Calculation of Plan Adjusted Index Rates and Calibrated Plan Adjusted Index Rates

			(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	
			= Product (Columns 1-6)						= Product (Columns 8-11)				= (7) x (12)		= (7) / (11)		
HIOS ID	Plan Name	Metal Tier	Membership	Market Adjusted Index Rate	AV & Cost Sharing	Distribution & Admin	Network & UM	Benefits in addition to EHBs	Impact of Eligibility (CAT)	Plan Adjusted Index Rate	Tobacco Calibration Factor	Age Calibration Factor	Geography Calibration Factor	Trend Factor	Calibration Factor	Calibrated Plan Adjusted Index Rate	AV Pricing Value
73987DC0040017	DC Gold HNOnly 70% \$25/40 T	Gold	18.00%	\$555.88	0.932	1.271	1.000	1.000	1.000	658.33	1.000	0.929	1.000	0.977	0.907	597.01	1.184
73987DC0040021	DC Gold HNOnly 500 90% \$25/40 E	Gold	18.00%	\$555.88	0.941	1.271	1.000	1.000	1.000	664.70	1.000	0.929	1.000	0.977	0.907	602.78	1.196
73987DC0040057	DC Silver HNOnly 4800 80% \$25/40 E	Silver	2.00%	\$555.88	0.761	1.271	1.000	1.000	1.000	537.71	1.000	0.929	1.000	0.977	0.907	487.63	0.967
73987DC0040046	DC Gold HNOnly 1650 100% HSA T	Gold	18.00%	\$555.88	0.866	1.271	1.000	1.000	1.000	611.69	1.000	0.929	1.000	0.977	0.907	554.72	1.100
73987DC0040029	DC Silver HNOnly 3000 100% HSA E	Silver	2.00%	\$555.88	0.805	1.271	1.000	1.000	1.000	568.57	1.000	0.929	1.000	0.977	0.907	515.61	1.023
73987DC0040056	DC Bronze HNOnly 6000 80% \$15/50 E	Bronze	22.00%	\$555.88	0.620	1.271	1.000	1.000	1.000	438.22	1.000	0.929	1.000	0.977	0.907	397.40	0.788
73987DC0040058	DC Gold HNOnly 1500 90% E	Gold	18.00%	\$555.88	0.880	1.271	1.000	1.000	1.000	621.81	1.000	0.929	1.000	0.977	0.907	563.89	1.119
73987DC0040059	DC Silver HNOnly 2800 90% HSA E	Silver	2.00%	\$555.88	0.808	1.271	1.000	1.000	1.000	571.14	1.000	0.929	1.000	0.977	0.907	517.94	1.027

Aetna Health Inc. (a PA corp.)  
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Exhibit 1  
2020 Rate Increases by Product

Product	Average Rate Increase	Minimum Rate Increase	Maximum Rate Increase
HealthNetworkOnlyOpenAccess	19.3%	7.5%	34.4%

Aetna Health Inc. (a PA corp.)  
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Exhibit 2  
Claim Impact due to Demographic Changes

Age	Experience Period Distribution		Experience Demographic Factor		Projected Period Distribution		Projection Demographic Factor	
	Male	Female	Male	Female	Male	Female	Male	Female
0	0.37%	0.29%	1.050	0.939	0.56%	0.46%	1.050	0.939
1	0.33%	0.77%	1.050	0.939	0.57%	0.49%	1.050	0.939
2	0.37%	0.73%	0.601	0.596	0.71%	0.49%	0.601	0.596
3	0.18%	0.29%	0.601	0.596	0.57%	0.50%	0.601	0.596
4	0.48%	0.26%	0.601	0.596	0.56%	0.51%	0.601	0.596
5	0.15%	0.62%	0.570	0.565	0.64%	0.56%	0.570	0.565
6	0.00%	0.00%	0.570	0.565	0.56%	0.55%	0.570	0.565
7	0.00%	0.40%	0.570	0.565	0.65%	0.50%	0.570	0.565
8	0.00%	0.51%	0.570	0.565	0.64%	0.67%	0.570	0.565
9	0.04%	0.00%	0.570	0.565	0.56%	0.67%	0.570	0.565
10	0.00%	0.00%	0.578	0.565	0.63%	0.70%	0.578	0.565
11	0.33%	0.29%	0.578	0.565	0.62%	0.61%	0.578	0.565
12	0.11%	0.15%	0.578	0.565	0.62%	0.63%	0.578	0.565
13	0.04%	0.04%	0.578	0.565	0.75%	0.60%	0.578	0.565
14	0.37%	0.55%	0.578	0.565	0.73%	0.59%	0.578	0.565
1	0.00%	0.00%	0.606	0.615	0.64%	0.63%	0.606	0.615
16	0.00%	0.00%	0.606	0.615	0.82%	0.67%	0.606	0.615
17	0.15%	0.00%	0.606	0.615	0.84%	0.63%	0.606	0.615
18	0.00%	0.00%	0.606	0.615	0.70%	0.64%	0.606	0.615
19	0.11%	0.00%	0.606	0.615	0.57%	0.70%	0.606	0.615
20	0.92%	0.62%	0.451	0.741	0.57%	0.77%	0.451	0.741
21	0.29%	0.44%	0.451	0.741	0.78%	0.67%	0.451	0.741
22	0.40%	0.51%	0.451	0.741	0.62%	0.64%	0.451	0.741
23	0.62%	1.62%	0.451	0.741	0.68%	0.75%	0.451	0.741
24	0.70%	0.88%	0.451	0.741	0.64%	0.66%	0.451	0.741
25	0.48%	0.88%	0.460	1.106	0.73%	0.79%	0.460	1.106
26	1.25%	2.53%	0.460	1.106	0.76%	0.99%	0.460	1.106
27	1.69%	1.84%	0.460	1.106	0.87%	0.92%	0.460	1.106
28	2.13%	1.40%	0.460	1.106	0.92%	0.94%	0.460	1.106
29	3.12%	1.21%	0.460	1.106	0.72%	0.93%	0.460	1.106
30	2.46%	2.17%	0.519	1.197	0.74%	0.91%	0.519	1.197
31	1.47%	0.70%	0.519	1.197	0.86%	0.95%	0.519	1.197
32	2.02%	0.40%	0.519	1.197	0.86%	0.97%	0.519	1.197
33	1.54%	0.70%	0.519	1.197	0.87%	0.98%	0.519	1.197
34	2.61%	1.03%	0.519	1.197	0.97%	0.87%	0.519	1.197
35	2.24%	0.62%	0.630	1.197	0.87%	1.03%	0.630	1.197
36	1.28%	0.15%	0.630	1.197	0.98%	1.03%	0.630	1.197
37	0.77%	0.84%	0.630	1.197	1.07%	1.04%	0.630	1.197
38	1.25%	1.06%	0.630	1.197	1.01%	0.87%	0.630	1.197
39	1.69%	1.69%	0.630	1.197	0.79%	0.83%	0.630	1.197
40	1.06%	0.95%	0.790	1.197	0.79%	0.82%	0.790	1.197
41	1.21%	0.40%	0.790	1.197	0.86%	0.94%	0.790	1.197
42	1.06%	0.70%	0.790	1.197	0.83%	0.84%	0.790	1.197
43	1.03%	0.62%	0.790	1.197	0.81%	0.73%	0.790	1.197
44	1.14%	0.00%	0.790	1.197	0.78%	0.78%	0.790	1.197
45	0.66%	0.00%	1.000	1.269	0.83%	0.81%	1.000	1.269
46	0.84%	0.62%	1.000	1.269	1.02%	0.85%	1.000	1.269
47	0.07%	0.26%	1.000	1.269	0.86%	0.86%	1.000	1.269
48	0.00%	0.26%	1.000	1.269	0.91%	0.88%	1.000	1.269
49	0.66%	0.66%	1.000	1.269	0.92%	0.97%	1.000	1.269
50	1.14%	0.29%	1.370	1.460	1.02%	0.75%	1.370	1.460
51	0.66%	0.48%	1.370	1.460	1.01%	0.92%	1.370	1.460
52	0.29%	0.88%	1.370	1.460	0.95%	0.92%	1.370	1.460
53	0.51%	0.51%	1.370	1.460	0.93%	0.93%	1.370	1.460
54	1.14%	2.31%	1.370	1.460	1.11%	0.86%	1.370	1.460
55	0.59%	1.28%	1.757	1.745	1.03%	0.85%	1.757	1.745
56	1.36%	1.43%	1.757	1.745	0.87%	0.75%	1.757	1.745
57	1.32%	0.37%	1.757	1.745	0.81%	0.72%	1.757	1.745
58	1.10%	0.37%	1.757	1.745	0.90%	0.73%	1.757	1.745
59	0.51%	1.80%	1.757	1.745	0.80%	0.69%	1.757	1.745
60	0.33%	1.14%	2.218	2.128	0.75%	0.62%	2.218	2.128
61	0.62%	1.03%	2.218	2.128	0.68%	0.63%	2.218	2.128
62	0.84%	0.95%	2.218	2.128	0.61%	0.58%	2.218	2.128
63	0.62%	0.29%	2.218	2.128	0.47%	0.40%	2.218	2.128
64	1.25%	0.11%	2.218	2.128	0.40%	0.34%	2.218	2.128
65+	2.02%	2.06%	3.200	2.700	0.71%	0.60%	3.200	2.700

Experience Period Demographic Factor	1.1248
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Note:

Experience Period Demographic Factor computed as the weighted average of gender specific Demographic Factor by current population distribution.

Projected Demographic Factor	1.0443
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Note:

Projected Demographic Factor computed as the weighted average of gender specific Demographic Factor by projected population distribution.

Demographic Change	0.9285
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Note:

Claim Impact due to Demographic Changes computed as the ratio of the Projected Demographic Factor over the Experience Period Demographic Factor.



Exhibit 3  
Projected Membership Distribution by County

Rating Area	Counties	Experience Period Membership	Experience Period Area Factor	Projected Membership	Projected Area Factor
1	District of Columbia	100%	1.000	100%	1.000

Average Experience Period Area Factor	1.0000
---------------------------------------	--------

**Note:**

Average Experience Period Area Factor computed as the weighted average of Experience Period Area Factors by experience period membership distribution.

Average Projected Area Factor	1.0000
-------------------------------	--------

**Note:**

Projected Area Factor computed as the weighted average of Projection Period Area Factors by projected membership distribution.

Area Shift Factor	1.0000
-------------------	--------

**Note:**

Area Shift Factor computed as the ratio of the Projected Membership by Area over the Experience Membership by Area Factor represents:

The impact due to the shift of the population distribution across areas.

Area Factor Change	1.0000
--------------------	--------

**Note:**

Area Factor Change computed as the ratio of the Projected Area Factor over the Experience Area Factor both using experience membership

Factor represents:

The impact due to cost relativity changes, including changes to provider networks and contracts, from the experience period to the rating period.

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Exhibit 4  
Projected Membership and Paid to Allowed by Metal Tier

Metallic Tier	Projected Membership	Projected Paid to Allowed Ratio
Platinum	0	N/A
Gold	36	88%
Silver	3	82%
Bronze	11	70%
Catastrophic	0	N/A
<b>Total</b>	50	84%

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Exhibit 5  
Retention as a Percent of Premium and PMPM

Retention Components	% of Premium	PMPM
Administrative Expense Load	9.91%	\$57.14
Profit & Risk Load	4.31%	\$24.84
Premium Tax	3.34%	\$19.25
User Exchange Fee	0.00%	\$0.00
State Based Exchange Fee	0.00%	\$0.00
HIF	2.60%	\$14.99
Risk Adjustment User Fee	0.03%	\$0.18
Federal Income Tax	1.15%	\$6.60
Total Taxes and Fees	7.12%	\$41.02

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**Exhibit 6**  
**MLR Projection**

			Formula
(a)	Premium (ppm)	\$576.43	
(b)	Medical Cost (ppm)	\$450.54	
(c)	Medical Benefit Ratio (MBR)	78.2%	= (c) / (b)
(d)	Quality Improvement Action (ppm)	\$4.61	= (a) x 0.80%
(e)	Taxes and Fees (ppm)	\$43.91	
(f)	Adjusted Premium (ppm)	\$532.52	=(a) - (e)
(g)	Adjusted Claims (ppm)	\$455.15	= (b) + (d)
	<b>Medical Loss Ratio (MLR)</b>	<b>85.5%</b>	=(g) / (f)

Notes:

ACA adjustments for QIA and taxes and fees are estimates based on historical experience and projected expenses.

Values reflect current actuarial projections and will differ from the final reported MLR.

This projection applies to the products included in this filing and is a standalone calculation for the 2020 calendar year. This projection differs from the MLR calculation specified by PPACA which includes three years of experience for all business in the MLR pool.

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Exhibit 7  
Quarterly Trend Factors

Effective Quarter	Membership	Med Trend + HIF Factor	Index Rate
1Q 2019	63.1%	1.000	\$566.81
2Q 2019	8.9%	1.029	\$583.51
3Q 2019	14.0%	1.060	\$600.71
4Q 2019	14.1%	1.091	\$618.41
Total	100.0%	1.024	\$580.28

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Exhibit 8  
Trend Exhibit

Service Type	Unit Cost	Utilization	Total
Facility Inpatient	5.9%	2.8%	8.9%
Facility Outpatient	4.1%	6.8%	11.2%
Physician	1.5%	6.3%	7.9%
Capitation	0.0%	0.0%	0.0%
Medical	4.2%	5.2%	9.6%
Pharmacy	11.7%	3.3%	15.4%
Total (Med + Rx)	5.8%	4.8%	10.8%

**Aetna Health Inc. (a PA corp.)****HIOS ISSUER ID: 73987****Exhibit 9****Sample Rate Calculation**

The following steps outline the mathematical formula used to develop the member level rates for a sample small group. The input assumptions and the census provided below are for illustrative purposes only.

**Sample Small Group Information:**

Effective Date: 01/01/2020  
 Rating Area: Rating Area 1  
 Plan: DC Silver HNOly 4800 80% \$25/40 E

<b><u>Group Census</u></b>	<b>Employee <u>Age</u></b>	<b>Spouse <u>Age</u></b>	<b>Child 1 <u>Age</u></b>	<b>Child 2 <u>Age</u></b>	<b>Child 3 <u>Age</u></b>
Employee 1	35	36	5	7	
Employee 2	56	52			
Employee 3	24	21			
Employee 4	52	49	19	17	16
Employee 5	65	65	25		
Employee 6	58	60	24		
Employee 7	56	51			
Employee 8	42	41			
Employee 9	33	34	5	6	7
Employee 10	25	28	2	1	

**Age and Tobacco****Factors****Age Factors**

	<b>Employee</b>	<b>Spouse</b>	<b>Child 1</b>	<b>Child 2</b>	<b>Child 3</b>
Employee 1	0.876	0.896	0.654	0.654	
Employee 2	1.801	1.545			
Employee 3	0.727	0.727			
Employee 4	1.545	1.377	0.654	0.654	0.654
Employee 5	2.181	2.181	0.727		
Employee 6	1.944	2.099	0.727		
Employee 7	1.801	1.487			
Employee 8	1.053	1.013			
Employee 9	0.836	0.856	0.654	0.654	0.654
Employee 10	0.727	0.744	0.654	0.654	

### Calculation of Monthly Premium

Step 1: Multiply Market Base Rate x Rating Area Factor x Plan Factor x Effective Date Factor

Market Base Rate =	\$640.86
x Rating Area Factor (Rating Area 1)	1.0000
x Plan Factor	0.7609
x Effective Date Factor	1.0000
Market Base Rate adjusted for Plan/Area/Effective Date =	\$487.63

Step 2: Multiply Adjusted Market Base Rate in Step 1 by the Member level Age and Tobacco Factors:

Member Monthly Rates	Employee	Spouse	Child 1	Child 2	Child 3	Total
Employee 1	\$427.16	\$436.92	\$318.91	\$318.91		\$1,501.90
Employee 2	\$878.22	\$753.39				\$1,631.61
Employee 3	\$354.51	\$354.51				\$709.02
Employee 4	\$753.39	\$671.46	\$318.91	\$318.91	\$318.91	\$2,381.58
Employee 5	\$1,063.52	\$1,063.52	\$354.51			\$2,481.55
Employee 6	\$947.95	\$1,023.53	\$354.51			\$2,325.99
Employee 7	\$878.22	\$725.10				\$1,603.32
Employee 8	\$513.47	\$493.97				\$1,007.44
Employee 9	\$407.66	\$417.41	\$318.91	\$318.91	\$318.91	\$1,781.80
Employee 10	\$354.51	\$362.80	\$318.91	\$318.91		\$1,355.13
<b>Group Total Monthly Premium:</b>						<b>\$16,779.34</b>

Note: Member level monthly rates are rounded to the nearest penny.



**Aetna Health Inc. (a PA corp.)**  
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**Exhibit 10**  
**Plan Mapping**

<b>2018 HIOS Plan ID</b>	<b>2018 Plan Name</b>	<b>2019 HIOS Plan ID</b>	<b>2019 Plan Name</b>	<b>2020 HIOS Plan ID</b>	<b>2020 Plan Name</b>
73987DC0040056	DC Bronze HMO 5000 80% HSA E	73987DC0040056	DC Bronze HMO 6000 80% HSA E	73987DC0040056	DC Bronze HNOOnly 6000 80% \$15/50 E
73987DC0040017	DC Gold HMO 70%	73987DC0040017	DC Gold HMO 70% T	73987DC0040017	DC Gold HNOOnly 70% \$25/40 T
73987DC0040021	DC Gold HMO 500 90%	73987DC0040021	DC Gold HMO 500 90% E	73987DC0040021	DC Gold HNOOnly 500 90% \$25/40 E
73987DC0040029	DC Silver HMO 3000 100% HSA E	73987DC0040029	DC Silver HMO 3000 100% HSA E	73987DC0040029	DC Silver HNOOnly 3000 100% HSA E
73987DC0040046	DC Gold HMO 1600 100% HSA T	73987DC0040046	DC Gold HMO 1600 100% HSA T	73987DC0040046	DC Gold HNOOnly 1650 100% HSA T
73987DC0040057	DC Silver HMO 4500 80%	73987DC0040057	DC Silver HMO 4800 80% E	73987DC0040057	DC Silver HNOOnly 4800 80% \$25/40 E
		73987DC0040058	DC Gold HMO 1000 100% E	73987DC0040058	DC Gold HNOOnly 1500 90% E
				73987DC0040059	DC Silver HNOOnly 2800 90% HSA E

**Aetna Life Insurance Company**  
**HIOS ISSUER ID: 77422**

**Exhibit 11**  
**Projected Age/Gender Distribution**

Age	Male	Female	DC Age Factor
0-14	9.34%	8.49%	0.654
15	0.64%	0.63%	0.654
16	0.81%	0.66%	0.654
17	0.84%	0.63%	0.654
18	0.69%	0.64%	0.654
19	0.56%	0.69%	0.654
20	0.57%	0.77%	0.654
21	0.78%	0.67%	0.727
22	0.62%	0.64%	0.727
23	0.68%	0.75%	0.727
24	0.64%	0.66%	0.727
25	0.73%	0.79%	0.727
26	0.76%	0.99%	0.727
27	0.87%	0.92%	0.727
28	0.92%	0.94%	0.744
29	0.72%	0.93%	0.760
30	0.74%	0.91%	0.779
31	0.86%	0.95%	0.799
32	0.86%	0.97%	0.817
33	0.87%	0.98%	0.836
34	0.97%	0.87%	0.856

<b>Age Calibration Factor</b>	1.077
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**Note:**

Age Calibration Factor  
computed as the weighted average of  
HHS Age Factor by projected membership  
distribution.

<b>Weighted Average Age</b>	43
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**Note:**

This is the age that most closely  
corresponds to the age calibration factor.

35	0.87%	1.03%	0.876
36	0.98%	1.03%	0.896
37	1.07%	1.04%	0.916
38	1.01%	0.87%	0.927
39	0.79%	0.83%	0.938
40	0.79%	0.82%	0.975
41	0.86%	0.94%	1.013
42	0.83%	0.84%	1.053
43	0.81%	0.73%	1.094
44	0.78%	0.78%	1.137
45	0.83%	0.81%	1.181
46	1.02%	0.85%	1.227
47	0.86%	0.86%	1.275
48	0.91%	0.88%	1.325
49	0.92%	0.97%	1.377
50	1.02%	0.75%	1.431
51	1.01%	0.92%	1.487
52	0.95%	0.92%	1.545
53	0.93%	0.93%	1.605
54	1.11%	0.86%	1.668
55	1.03%	0.85%	1.733
56	0.87%	0.75%	1.801
57	0.81%	0.72%	1.871
58	0.90%	0.73%	1.944
59	0.80%	0.69%	2.020
60	0.75%	0.62%	2.099
61	0.68%	0.63%	2.180
62	0.61%	0.58%	2.180
63	0.47%	0.40%	2.180
64	0.40%	0.34%	2.180
65+	0.71%	0.60%	2.180

**Aetna Health Inc. (a PA corp.)**  
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**Exhibit A-1**  
**Rate Change by Plan**

2019 HIOS Plan ID	2019 Plan Name	1Q2019 Premium Rate	2020 HIOS Plan ID	2020 Plan Name	1Q2020 Premium Rate	Rate Change
73987DC0040058	DC Gold HMO 1000 100% E	\$379.58	73987DC0040058	DC Gold HNOOnly 1500 90% E	\$409.86	8.0%
73987DC0040021	DC Gold HMO 500 90% E	\$365.66	73987DC0040021	DC Gold HNOOnly 500 90% \$25/40 E	\$438.13	19.8%
73987DC0040046	DC Gold HMO 1600 100% HSA T	\$364.59	73987DC0040046	DC Gold HNOOnly 1650 100% HSA T	\$403.19	10.6%
73987DC0040017	DC Gold HMO 70% T	\$337.39	73987DC0040017	DC Gold HNOOnly 70% \$25/40 T	\$433.93	28.6%
73987DC0040056	DC Bronze HMO 6000 80% HSA E	\$213.99	73987DC0040056	DC Bronze HNOOnly 6000 80% \$15/50 E	\$288.85	35.0%
73987DC0040029	DC Silver HMO 3000 100% HSA E	\$298.39	73987DC0040029	DC Silver HNOOnly 3000 100% HSA E	\$374.77	25.6%
73987DC0040057	DC Silver HMO 4800 80% E	\$269.28	73987DC0040057	DC Silver HNOOnly 4800 80% \$25/40 E	\$354.43	31.6%

DC Gold HNOOnly 70% \$25/40 T

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐  
Apply Inpatient Copay per Day? ☐  
Apply Skilled Nursing Facility Copay per Day? ☐  
Use Separate MOOP for Medical and Drug Spending? ☐  
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier: Gold

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)	\$0.00	\$0.00
Coinsurance (%; Insurer's Cost Share)	70.00%	100.00%
MOOP (\$)	\$7,600.00	
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	78%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	70%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	
Specialty Rx Coinsurance Maximum: \$150	
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10):	

### Plan Description:

Name: DC Gold HNOOnly 70% \$25/40 T  
Plan HIOS ID: 73987DC0040017  
Issuer HIOS ID: 73987

### Output

Calculate

Status/Error Messages:

Actuarial Value: 81.92%

Metal Tier: Gold

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time:

0.0625 seconds

Final 2020 AV Calculator

This product, DC Gold HNOOnly 70% \$25/40 T, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 81.92%

DC Gold HNOOnly 500 90% \$25/40 E

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐  
Apply Inpatient Copay per Day? ☐  
Apply Skilled Nursing Facility Copay per Day? ☐  
Use Separate MOOP for Medical and Drug Spending? ☐  
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier: Gold

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)	\$500.00	\$0.00
Coinsurance (%; Insurer's Cost Share)	90.00%	100.00%
MOOP (\$)	\$7,900.00	
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	88%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$250.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$150
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

### Plan Description:

Name: DC Gold HNOOnly 500 90% \$25/40 E  
Plan HIOS ID: 73987DC0040021  
Issuer HIOS ID: 73987

### Output

Calculate

Status/Error Messages:

Actuarial Value: 79.77%

Metal Tier: Gold

Additional Notes:

NOTE: One or more services are not subject to the deductible and have no copay. Any service with this cost-sharing structure is covered at 100% by the plan in the deductible range. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Calculation Time:

0.0312 seconds

Final 2020 AV Calculator

This product, DC Gold HNOOnly 500 90% \$25/40 E, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.77%

DC Silver HNOnly 4800 80% \$25/40 E

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐  
Apply Inpatient Copay per Day? ☐  
Apply Skilled Nursing Facility Copay per Day? ☐  
Use Separate MOOP for Medical and Drug Spending? ☐  
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier: Silver

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)	\$4,800.00	\$0.00
Coinsurance (%; Insurer's Cost Share)	80.00%	100.00%
MOOP (\$)	\$7,900.00	
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$750.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	64%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$250.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	
Specialty Rx Coinsurance Maximum: \$150	
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10):	

### Plan Description:

Name: DC Silver HNOnly 4800 80% \$25/40 E  
Plan HIOS ID: 73987DC0040057  
Issuer HIOS ID: 73987

### Output

Calculate

### Status/Error Messages:

Actuarial Value: 72.00%

Metal Tier: Silver

### Additional Notes:

NOTE: One or more services are not subject to the deductible and have no copay. Any service with this cost-sharing structure is covered at 100% by the plan in the deductible range. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

### Calculation Time:

0.0469 seconds

### Final 2020 AV Calculator

This product, DC Silver HNOnly 4800 80% \$25/40 E, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 72.00%

## DC Gold HNOOnly 1650 100% HSA T

### Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

#### User Inputs for Plan Parameters

- ☒ Use Integrated Medical and Drug Deductible?  
☐ Apply Inpatient Copay per Day?  
☐ Apply Skilled Nursing Facility Copay per Day?  
☐ Use Separate MOOP for Medical and Drug Spending?  
☐ Indicate if Plan Meets CSR or Expanded Bronze AV Standard?

Desired Metal Tier: Gold

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		\$1,650.00
		90.00%
		\$3,950.00

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

#### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$150
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

#### Plan Description:

**Name:** DC Gold HNOOnly 1650 100% HSA T  
**Plan HIOS ID:** 73987DC0040046  
**Issuer HIOS ID:** 73987

#### Output

#### Status/Error Messages:

**Actuarial Value:** 80.55%  
**Metal Tier:** Gold

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

#### Additional Notes:

**Calculation Time:** 0.0312 seconds

#### Final 2020 AV Calculator

**Option 3 Additive TIF adj:** -1.00%  
**Final AV:** 79.55%

This product, DC Gold HNOOnly 1650 100% HSA T, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.55%



## DC Silver HNOnly 3000 100% HSA E

### Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

#### User Inputs for Plan Parameters

- ☒ Use Integrated Medical and Drug Deductible?  
☐ Apply Inpatient Copay per Day?  
☐ Apply Skilled Nursing Facility Copay per Day?  
☐ Use Separate MOOP for Medical and Drug Spending?  
☐ Indicate if Plan Meets CSR or Expanded Bronze AV Standard?

Desired Metal Tier: **Silver**

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$3,000.00
Coinsurance (%; Insurer's Cost Share)		90.00%
MOOP (\$)		\$6,500.00
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$75.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

#### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$150
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

#### Plan Description:

**Name:** DC Silver HNOnly 3000 100% HSA E  
**Plan HIOS ID:** 73987DC0040029  
**Issuer HIOS ID:** 73987

#### Output

Calculate

Status/Error Messages:

Actuarial Value: 71.34%  
 Metal Tier: Silver

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.0449 seconds

Final 2020 AV Calculator

This product, DC Silver HNOnly 3000 100% HSA E, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 71.34%

DC Bronze HNOOnly 6000 80% \$15/50 E

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒  
Apply Inpatient Copay per Day? ☒  
Apply Skilled Nursing Facility Copay per Day? ☒  
Use Separate MOOP for Medical and Drug Spending? ☐  
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier: **Bronze**

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$6,000.00
Coinsurance (%; Insurer's Cost Share)		100.00%
MOOP (\$)		\$7,900.00
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	91%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$250.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$300.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>	
Specialty Rx Coinsurance Maximum: \$150	
Set a Maximum Number of Days for Charging an IP Copay? <input checked="" type="checkbox"/>	
# Days (1-10): 5	
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	
# Copays (1-10):	

### Plan Description:

Name: DC Bronze HNOOnly 6000 80% \$15/50 E  
Plan HIOS ID: 73987DC0040056  
Issuer HIOS ID: 73987

### Output

Status/Error Messages:

Actuarial Value: 61.06%

Metal Tier: Bronze

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time:

0.0469 seconds

Final 2020 AV Calculator

This product, DC Bronze HNOOnly 6000 80% \$15/50 E, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 61.06%

DC Gold HNOOnly 1500 90% E

## Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

### User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐  
Apply Inpatient Copay per Day? ☐  
Apply Skilled Nursing Facility Copay per Day? ☐  
Use Separate MOOP for Medical and Drug Spending? ☐  
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? ☐

Desired Metal Tier: Gold

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$0.00
Coinsurance (%; Insurer's Cost Share)	90.00%	100.00%
MOOP (\$)	\$7,500.00	
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	94%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$65.00	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	100%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$150
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

### Plan Description:

Name: DC Gold HNOOnly 1500 90% E  
Plan HIOS ID: 73987DC0040058  
Issuer HIOS ID: 73987

### Output

Calculate

Status/Error Messages:

Actuarial Value: 79.17%  
Metal Tier: Gold

Additional Notes:

NOTE: One or more services are not subject to the deductible and have no copay. Any service with this cost-sharing structure is covered at 100% by the plan in the deductible range. NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Calculation Time:

0.0312 seconds

Final 2020 AV Calculator

This product, DC Gold HNOOnly 1500 90% E, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.17%

## DC Silver HNOnly 2800 90% HSA E

### Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

#### User Inputs for Plan Parameters

- ☒ Use Integrated Medical and Drug Deductible?  
☐ Apply Inpatient Copay per Day?  
☐ Apply Skilled Nursing Facility Copay per Day?  
☐ Use Separate MOOP for Medical and Drug Spending?  
☐ Indicate if Plan Meets CSR or Expanded Bronze AV Standard?

Desired Metal Tier: **Silver**

HSA/HRA Options	Tiered Network Option
HSA/HRA Employer Contribution? <input type="checkbox"/>	Tiered Network Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$2,800.00
Coinsurance (%; Insurer's Cost Share)		90.00%
MOOP (\$)		\$6,750.00
MOOP if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2				Tier 1	Tier 2
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	71%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
All Inpatient Hospital Services (inc. MH/SUD)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input type="checkbox"/> All	<input type="checkbox"/> All
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$12.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$55.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$95.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	60%		<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

#### Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$150
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

#### Plan Description:

**Name:** DC Silver HNOnly 2800 90% HSA E  
**Plan HIOS ID:** 73987DC0040059  
**Issuer HIOS ID:** 73987

#### Output

#### Status/Error Messages:

**Actuarial Value:** 71.31%  
**Metal Tier:** Silver

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

#### Additional Notes:

**Calculation Time:** 0.0469 seconds

**Final 2020 AV Calculator**

This product, DC Silver HNOnly 2800 90% HSA E, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 71.31%

**RATE FILING REQUIREMENTS INDIVIDUAL AND SMALL GROUP  
PLANS SOLD ON DC HEALTH LINK  
CHECK-LIST**

INSTRUCTIONS: Include all required elements in the table below with the filed rates. The data elements listed in the Actuarial Memorandum should be consistent with the cover letter, if applicable.

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
1	Purpose of Filing	State the purpose of the filing. Identify the applicable law. List the proposed changes to the base rates and rating factors, and provide a general summary.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 1
2	Form Numbers	Form numbers should be listed in the actuarial memorandum.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 11
3	HIOS Product ID	The HIOS product ID should be listed in the actuarial memorandum.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 1
4	Effective Date	The requested effective date of the rate change. For filings effective 1/1/2018 and later, follow filing due date requirements.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 1
5	Market	Indicate whether the products are sold in the individual or small employer group market.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 1
6	Status of Forms	Indicate whether the forms are open to new sales, closed, or a mixture of both, and whether the forms are grandfathered, non- grandfathered, or a mixture of both.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 1
7	Benefits/Metal level(s)	Include a basic description of the benefits of the forms referenced in the filing and the metal level of each plan design.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 1-2
Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
7.1	AV Value	Provide the actuarial value of each plan design using the AV calculator developed and made available by HHS.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 1-2, Exhibit A
8	Average Rate Increase Requested	The weighted average rate increase being requested, incremental and year-over-year renewal. The weights should be based on premium volume. <b>In the small group market, please also provide weighted average rate increase requested for 2017Q1 over 2016Q1; etc.</b>	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 2
9	Maximum Rate Increase Requested	The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 2
10	Minimum Rate Increase Requested	The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 2
11	Absolute Maximum Premium Increase	The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes such as aging.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 2
12	Average Renewal Rate Increase for a Year	Calculate the average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing. The calculation must be performed for each HIOS product ID.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 2

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
13	Rate Change History	Rate change history of the forms referenced in the filing. If nationwide experience is used in developing the rates, provide separately the rate history for District of Columbia and the nationwide average rate history.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 2-3
14	Exposure	Current number of policies, certificates and covered lives.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 3
15	Member Months	Number of members in force during each month of the base experience period used in the rate development and in each of the two preceding twelve-month periods.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 3
16	Past Experience	Provide monthly earned premium and incurred claims for the base experience period used in the rate development and each of the two preceding twelve-month periods.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 3, 10
17	Index Rate	Provide the index rate.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 3
17.1	Rate Development	Show base experience used to develop rates and all adjustments and assumptions applied to arrive at the requested rates. For less than fully credible blocks, disclose the source of the base experience data used in the rate development and discuss the appropriateness of the data for pricing the policies in the filing.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 3-5
18	Credibility Assumption	If the experience of the policies included in the filing is not fully credible, state and provide support for the credibility formula used in the rate development.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 5
19	Trend Assumption	Show trend assumptions by major types of service as defined by HHS in the Part I Preliminary Justification template, separately by unit cost, utilization, and in total. Provide the development of the trend assumptions.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 5-6
20	Cost-Sharing Changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost- sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 6
21	Benefit Changes	Disclose any changes in covered benefits for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for changes in covered benefits in the rate development. Provide support for the estimated cost impact of the benefit changes.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 6, Exhibit E-2

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
22	Plan Relativities	For rate change filings, if the rate change is not uniform for all plan designs, provide support for all requested rate changes by plan design. Disclose the minimum, maximum, and average impact of the changes on policyholders. For initial filings, provide the derivation of any new plan factors.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 6, Exhibit E-2
23	Rating Factors	Provide the age and other rating factors used. Disclose any changes to rating factors, and the minimum, maximum, and average impact on policyholders. Provide support for any changes.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 6, Exhibit 3, Exhibit 7, Exhibit 11
23.1	Wellness Programs	Describe any wellness programs (as defined in section 2705(j) of the PHS Act) included in this filing.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 6-7
24	Distribution of Rate Increases	Anticipated distribution of rate increases due to changes in base rates, plan relativities, and rating factors. This need not include changes in demographics of the individual or group.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 7, Exhibit A-1
25	Claim Reserve Needs	Provide the claims for the base experience period separately for paid claims, and estimated incurred claims (including claim reserve). Indicate the incurred period used for the base period. Indicate the paid-through date of the paid claims, and provide a basic description of the reserving methodology for claims reserves and contract reserves, if any. Provide margins used, if any.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 7
26	Administrative Costs of Programs that Improve Health Care Quality	Show the amount of administrative costs included with claims in the numerator of the MLR calculation . Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 7
Number	Data Element	Requirement Description	Individual/and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
27	Taxes and Licensing or Regulatory Fees	Show the amount of taxes, licenses, and fees subtracted from premium in the denominator of your medical loss ratio calculation(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 7, Exhibit 6
28	Medical Loss Ratio (MLR)	Demonstrate that the projected loss ratio, including the requested rate change, meets the minimum MLR. Show the premium, claims, and adjustments separately with the development of the projected premium and projected claims (if not provided in the rate development section). If the loss ratio falls below the minimum for the subset of policy forms in the filing, show that when combined with all other policy forms in the market segment in District of Columbia, the loss ratio meets the minimum.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 7, Exhibit 6

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
29	Risk Adjustment	Provide rate information relating to the Risk Adjustment program. Information should include assumed Risk Adjustment user fees, Risk Adjustment PMPM excluding user fees and assumed distribution of enrollment by risk score, plan, and geographical area. Provide support for the assumptions, including any demographic changes. Provide information/study on the development of risk scores and Risk Adjustment PMPM. Provide previous year-end estimated risk adjustment payable or receivable amount and quantitative support for the amount.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 7-8
30	Past and Prospective Loss Experience Within and Outside the State	Indicate whether loss experience within or outside the state was used in the development of proposed rates. Provide an explanation for using loss experience within or outside the state.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 8
31	A Reasonable Margin for Reserve Needs	Show the assumed Margin for Reserve Needs used in the development of proposed rates. Margin for Reserve Needs includes factors that reflect assumed contributions to the company's surplus or the assumed profit margin. Demonstrate how this assumption was derived, how the assumption has changed from prior filings, and provide support for changes. If the assumption for Qualified Health Plans exceeds 3% as assumed in the risk corridor formula, justify the excess in light of the company's surplus position.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 8, Exhibit 5
Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
32	Past and Prospective Expenses	Indicate the expense assumptions used in the development of proposed rates. Demonstrate how this assumption was derived. Show how this assumption has changed from prior filings, and provide support for any change. Provide the assumed administrative costs in the following categories: <ul style="list-style-type: none"> <li>• Salaries, wages, employment taxes, and other employee benefits</li> <li>• Commissions</li> <li>• Taxes, licenses, and other regulatory fees</li> <li>• Cost containment programs / quality improvement activities</li> <li>• All other administrative expenses</li> <li>• Total</li> </ul>	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 8
33	Any Other Relevant Factors Within and Outside the State	Show any other relevant factors that have been considered in the development of the proposed rates. Demonstrate how any related assumptions were derived. Show how these assumptions have changed from prior filings, and provide support for any change.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 8
34	Other	Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q20 IVL.doc - pg 9



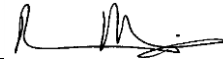
Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
35	Actuarial Certification	Signed and dated certification by a qualified actuary that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of the District of Columbia and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the rates are not unfairly discriminatory.	Yes	DC Small Group Actuarial Memorandum - AHI 1 Q20 IVL.doc - pg 9
36	Part I Preliminary Justification (Grandfathered Plan Filings)	Rate Summary Worksheet --- Provide this document with all Grandfathered plan filings. <b>Provide in Excel and PDF format.</b>	N/A	N/A
36.1	Unified Rate Review Template (Non-Grandfathered Filings)	Unified Rate Review Template as specified in the proposed Federal Rate Review regulation. Provide this document with all Non-Grandfathered plan filings. <b>Provide in Excel and PDF format.</b>	Yes	Supporting Documentaion
37	Part II Preliminary Justification	Written description justifying the rate increase as specified by 45 CFR § 154.215(f). Provide for <i>all</i> individual and small employer group filings (whether or not they are “subject to review” as defined by HHS).	Yes	Supporting Documentation
38	DISB Actuarial Memorandum Dataset	Summarizes data elements contained in Actuarial Memorandum. Provide this document with all Non- Grandfathered plan filings. <b>Provide in Excel format only.</b>	Yes	Supporting Documentation
39	District of Columbia Plain Language Summary	Similar to the Part II Preliminary Justification, this is a written description of the rate increase as specified by 45 CFR § 154.215, but as a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. Provide this document for all individual and small employer group filings.	Yes	Supporting Documentation
40	Summary of Components for Requested Rate Change	DISB will require that issuers provide a chart listing a) any and all components of requested rate changes from the prior year; b) a quick summary/explanation of the change; and c) the actual percentage impact of the change for each component, such that the total for all components listed equals the total percentage change requested for the plan year.	Yes	Supporting Documentation

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
41	CCIO Risk Adjustment Transfer Elements Extract (RATE 'E')	Received directly from CCIO; this report should be completed and submitted by the set deadline for QHP submissions, or by <b>April 30th</b> of the current year, whichever is first.	Yes	Supporting Documentation
42	Additional Requirements for Stand-Alone Dental Plan Filings	Provide the following for stand-alone dental plan filings: <ul style="list-style-type: none"> <li>• Identification of the level of coverage (i.e. low or high), including the actuarial value of the plan determined in accordance with the proposed rule;</li> <li>• Certification of the level of coverage by a member of the American Academy of Actuaries using generally accepted actuarial principles; and</li> <li>• Demonstration that the plan has a reasonable annual limitation on cost-sharing.</li> </ul>	N/A	N/A

#### CERTIFYING SIGNATURE

The undersigned representative of the organization submitting this rate filing attests that all items contained in the above checklist have been included in the filing to the best of the company's ability.

Regis Murayi  
 \_\_\_\_\_  
 (Print Name)

  
 \_\_\_\_\_  
 (Signature)

**Aetna Health Inc. (a PA corp.)**

**HIOS ISSUER ID: 73987**

<u>Components of 1Q19 to 1Q20 Rate Change</u>	No Risk Adjustment Merger	With Risk Adjustment Merger
2019 Approved Trend	12.3%	12.3%
Proposed 1/1/2020 Base Rate Increase	-4.2%	-4.0%
HIF reinstatement	2.6%	2.6%
Benefit Design Changes	6.0%	6.0%
Impact of Individual-Small Group Risk Adjustment Merger	0.0%	3.0%
Total 1Q2019 to 1Q2020 Rate Change	16.7%	19.9%

SERFF Tracking #:

AETN-131944461

State Tracking #:

Company Tracking #:

DCAHISG2020

State:

District of Columbia

Filing Company:

Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name:

DC AHI SG HMO 2020

Project Name/Number:

2020 Exchange - Aetna/HMO

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/28/2019		Rate	DC AHI SG HMO 2020	05/29/2019	DC_SG_73987_Rates_ON_1Q2020_v1a.xlsm DC_SG_73987_Rates_ON_1Q2020_v1a_IVL.xlsm
05/24/2019		Supporting Document	Supporting Documentation	05/28/2019	ACT Memo Exhibits from FACT_DC - AHI - 1Q2020.pdf Exhibit 12 - AHI Key Factors.pdf Exhibit A-1 - AHI Rate Change by plan.pdf Exhibit A-2_DC_SG_73987_AV_Screenshots_2020.pdf 2020Aetna AVCCert Template_DC_AHI.pdf DISB Filing Checklist - AHI 2020.pdf ACT Memo Exhibits from FACT_DC - AHI - 1Q2020 IVL.pdf Exhibit A-1 - AHI Rate Change by plan IVL.pdf Exhibit A-2_DC_SG_73987_AV_Screenshots_2020.pdf Exhibit 12 - AHI Key Factors IVL.pdf DISB Filing Checklist - AHI 2020 IVL.pdf
05/17/2019		Rate	DC AHI SG HMO 2020	05/28/2019	DC_SG_73987_Rates_ON_1Q2020_v1.xlsm (Superceded) DC_SG_73987_Rates_ON_1Q2020_v1_IVL.xlsm (Superceded)

<b>SERFF Tracking #:</b>	AETN-131944461	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	DCAHISG2020
<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV		
<b>TOI/Sub-TOI:</b>	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO				
<b>Product Name:</b>	DC AHI SG HMO 2020				
<b>Project Name/Number:</b>	2020 Exchange - Aetna/HMO				

***Attachment DC\_SG\_73987\_Rates\_ON\_1Q2020\_v1.xlsm is not a PDF document and cannot be reproduced here.***

***Attachment DC\_SG\_73987\_Rates\_ON\_1Q2020\_v1\_IVL.xlsm is not a PDF document and cannot be reproduced here.***